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THE TRAINING OF UNDERGRADUATES AND GRADUATES IN MEDICINE, WITH SOME REMARKS ON THE PRACTICE OF MEDICINE IN QUEENSLAND.

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In the year 1917 Professor Mungo MacCallum (for thirty-four years Professor of English in the University of Sydney) delivered an address to the Sydney University Medical Society, entitled "Professionalism and Humanism", in which he made the following remarks:

... by "professionalism" I mean devotion to one's own vocation, whatever that happens to be—Medicine or Law or Literature or anything else; ... By "humanism" I mean interest in all that pertains to us as men, and especially in what pertains to us peculiarly as men and does not pertain to the lower animals.

Professor MacCallum told his audience that they should "understand by professionalism, disinterested zeal for one's profession as such, so that one wishes to be as good in it as one can possibly be And by humanism, understand the preparation of the mind that will enable it to appreciate all the general concerns of human beings, but more distinctively such as appeal, not to the physical, but to the spiritual side of their nature."

Forty years later, F. M. R. Walshe (1952) said: "We are a learned profession with the moral and intellectual responsibilities of a profession It is a way of life that demands of us speculative and practical wisdom as well as knowledge."

First let us consider some aspects of how the doctor is to be trained both as an undergraduate and as a young graduate, so that he may bring to the practice of medicine a balance of professionalism and humanism.

It would appear that medicine over the last thirty years or more has been pursuing a course that is not altogether in the best interests of the community, in that there have developed two types of doctors—general practitioners and specialists—whose work is not as well coordinated as it might be.

Until the end of the 1914-1918 war all doctors received the same sort of training. A very large percentage of them became general practitioners, the majority of whom, after one or two years as resident medical officers in public hospitals, entered general practice. However, many were compelled to commence practice immediately on graduation, as there were not enough positions in hospitals to satisfy the needs of each year's graduates. Almost all those who became specialists spent a number of years in general practice.

In my opinion, the period from the time when the medical schools of Australia were founded until the end of the World War of 1914-1918 produced medical practitioners equal to the best.

Changes After 1918.

Since the end of the war of 1914-1918 there have been great changes in our way of life, but not nearly so many changes in the medical curriculum. Students nowadays are taught by various specialists, such as professors of anatomy, physics, chemistry, physiology, pathology, medicine and surgery *et cetera*, and these men, very few of whom have ever been in general practice, arrange the medical curriculum.

All attempts at any worthwhile reform of the curriculum have failed. Some thirty years ago there was a meeting in London to review the medical curriculum, but nothing came of it because, while every one of those present was desirous of reducing the other man's amount of teaching, no one was willing to reduce his own. Lord Moran has described the position of the student very truly when he wrote his article on "The Student in Irons".

The community must be served by general practitioners and specialists, and a way must be found to make their work complementary, somewhat along the lines of that of a solicitor and a barrister. At a certain stage it should be obvious to the well-trained practitioner that a patient's condition requires the opinion of someone with specialized knowledge, and it must be arranged that he seek such help for the good of his patient. Conversely, the specialist should not treat patients for illnesses that are recognized as coming within the scope of general practice.

The first world conference on medical education which has been arranged by the World Health Organization and the World Medical Association took place in London in August, 1953, and its programme was published in the *British Medical Journal* (1953); it should go far to provide the solution to the problems they are facing in the profession.

The only worthwhile change in the medical curriculum has been to increase the time of training by one year, and the curriculum is being continually added to and overloaded. Very much of this training is more suitable for those who are going to become specialists than for incipient general practitioners. We have a curriculum which, though good in parts, is not as suitable as is desirable for one who is to become a general practitioner.

There is very much dissatisfaction with the training of doctors. The journal *Health* (1953) states that the 1947 census showed that 65% of graduates become general practitioners and only 12% specialists. It is unreasonable, then, that most practitioners of long and good standing in general practice should not have a part to play in the arranging of a curriculum for undergraduates.

In the United States of America they have founded an Academy of General Practice, and in Great Britain the College of General Practice has recently been formed; one of its objects, if I understand aright, is to give advice on the sort of education that should be provided for general practice.

Matriculation.

Professor MacCallum was of the opinion that "the liberal education guaranteed by a matriculation pass is, in amount and character, absurdly inadequate". If this is a sound opinion, and matriculation was no guarantee that a person had had a satisfactory education in 1917, the position in 1953 leaves even more to be desired.

Let us consider what is necessary for matriculation of medical students. Romano (1950) has stated that "the collegiate pre-professional training is apt to be much more thorough and inclusive in physics, chemistry and biology than it is in psychology, sociology, history and literature".

In addition to the treatment of the acute illness of patients, Romano has pointed out that students require to know much more about the treatment of chronic patients.

This is particularly so with patients who do not respond immediately to treatment and those in whom there is no remarkable change in the experience of pain or disability over a long period. . . . Problems of prolonged convalescence, chronic disease and disability . . . and the continued responsibility for the care of the

chronically sick person adds immeasurably to the education of the physician. . . .

In certain University teaching hospitals . . . there is a tendency to admit for study only diagnostic dilemmas, and at times this turns into what might be called "clinical stamp collecting".

. . . in military service . . . many of the young physicians appeared to be bored and impatient with men who suffered the most common complaints of mankind—headache, backache and bellyache—and felt that they were acting as dignified physicians only when they were presented with evidence of the rarer and more obscure types of disease.

A leading article in *THE MEDICAL JOURNAL OF AUSTRALIA* (1953) calls attention to the report on medical education published by the British Medical Association in 1948:

It described as forming the general educational background of an ordinary cultured citizen, a curriculum which would include English language and literature, history, one or more foreign languages, geography, elementary mathematics, general science.

Exactly what general science is I do not know, nor do I know of any text-book that is adequate for the teaching of such a subject.

In Queensland the primary school curriculum has been revised, and in addition to the "three R's" students receive training according to their age in science and the social sciences. By the time they leave the primary school they should be well enough advanced to understand all that is required by an ordinary citizen to appreciate what is written, in the daily newspapers, on science and social science, and should have a good general knowledge of governments and the like.

The study of science should be very elementary at first, the teacher telling of simple matters of everyday life met with in the kitchen and the home and the environment of the child generally. The child is thus introduced in a very elementary way to chemistry, physics and biology in the world about him. The facts of the universe may be considered as an elementary study of astronomy. The more practical aspect of this work may be illustrated by many examples in the kitchen and the home, and the biological sciences are introduced by a study of growing plants and the study of animals. Our social institutions are explained, and by the time when the child has finished his primary education he should have a very fair knowledge of the principles of science and the principles of government and have learned something of his duties and responsibilities as well as of his many privileges.

We should do well to remember in the teaching of students the old proverb: "A man learns one-tenth of what he hears, one-third of what he reads, one-half of what he sees, but nine-tenths of what he does."

There has been a very great need for this type of education in addition to the education in the subjects that we have insisted on in the past, because after all this is the study that fits the child and the young adult for citizenship.

Consider for a moment those who are members of the so-called "uncivilized races"—for example, the Australian aborigines. The aboriginal boy is trained in various ways in the skills that enable him to live, and learns about the various tribal customs that have been handed down from generation to generation, so that when he is initiated into the tribe he is well informed on its past history and has a very good idea of what is expected of him.

Much of our study in the past has been very pedantic—for example, in the matter of English. Students are expected to study the subjects as they would study anatomy, and they lose much of the humanistic side which this study should give in the process. It was Anthony Quayle who said recently, in a "Guest of Honour" broadcast, that the plays of Shakespeare should be studied as a whole and students should see their performance as they were meant to be seen by the earlier audiences.

It is suggested that the plays should be selected with due regard to the age of the students. The comedies are better suited for the younger members of the community, the tragedies when the audience is psychologically capable of appreciating them.

Secondary Education.

The students, having passed out of the primary stage of education, enter upon the secondary stage. Secondary education has been the subject of a report by seven university professors, which has been seen by the faculties and sent to the Senate, who have referred the matter to the Board of Post-Primary Studies. They in turn sent it to the Government, and there it remains at present, and we are waiting to hear what has been decided.

The proposals that have been made by the seven professors are to ensure that all students receive a somewhat similar education up to the age of sixteen years. Only three subjects should be compulsory—English, social science and science. Students will have a wide choice of other subjects. All students will be required to take a leaving examination.

Students who intend to go to the University will be required to spend an extra year in the secondary school (two years for preference), which will be given over to a continuation of some of the subjects that they have already taken, and of the subjects that they are required to take for matriculation.

From then on the student commences his professional course at the university, and it is necessary to ask ourselves: "How can we reconcile the claims of professionalism and humanism?" His previous education in the primary and secondary schools (if what has been said is adopted) should tend to keep in mind the claims of humanism, especially as has been suggested by Romano (1950), if subjects like sociology are studied in the first and second years of the course.

Some Views about the Teaching of Science.

The leading article in the *British Medical Journal* of February 28, 1953, makes the following statement:

Reports on medical education so often pay lip service to the need for a broad education in the humanities, and then we see our ancient Universities in this country insisting that a boy or a girl should pass the First M.B. before going, for example, to Oxford or Cambridge. This often forces the schoolboy into specialization in the basic sciences, and the schoolmaster, with the examination hurdle in mind, finds it difficult to provide an education that will fit the boy to be an intelligent citizen of the world.

Again, a leading article in *THE MEDICAL JOURNAL OF AUSTRALIA* (1953) refers to "... a thorough training in the methodology of science, which could be best inculcated in a special course in science at a university standard and in a university atmosphere".

First a little must be interpolated about the teaching of these subjects in schools. Of two of our professors, one told me that at secondary school in another State he received under a very competent master most valuable courses in physics and chemistry, both theoretical and practical, far more satisfactory than those at the universities. The other said that he had conducted a course in physics for the senior boys, and this course, both theoretical and practical, was much better than the corresponding one at the university.

Education at the University.

The university student in many cases listens to lectures by professors who have to deal with very large classes. The very size of the classes (there were several hundred in the immediate post-war period) and the presence of students from various faculties preclude the student from getting any personal contact with the professor. The advantages that a limited number in school classes have with a master is lost.

The so-called "practical work" in the university is handed over to demonstrators, and in many cases these people are constantly changing and are themselves students not much in advance of those whom they instruct.

Douglas McKie, writing in the *Universities Quarterly* for February, 1952, on the history and philosophy of science, makes the following statement:

The popular modern belief in the existence of a peculiarly "scientific method" is merely an illusion. There is no such thing as a "scientific method", no process peculiar to scientific thought and practice and discovery.

The history of science, considered as a subject of University study, provides a great field for research, both in itself and with regard to general history.

Far too little is being done by the Universities as yet with regard to the prosecution of studies in the history and philosophy of science and the remedying of some of the serious defects in our educational system, defects which are so frequently deplored.

Our Canadian colleagues seem to have done much better than we have done, and just recently a student was admitted to the second year of the Faculty of Medicine of the University of Queensland, who had been well educated in the liberal arts and sciences. He had studied bacteriology, biology, chemistry, English, geology, German, mathematics, philosophy, physics, psychology and zoology. In Canada this led up to the degree of bachelor of arts, and he was able to enter the second year of our medical course.

Education is a continuing process; in Queensland, as has been said, it commences with the education of the child when he enters upon his sixth year of life, and goes on, in the case of medical students, to the beginning of the eighteenth year, when he matriculates. The average age for matriculation is about seventeen and a half to eighteen years. Thereafter his education continues until his twenty-third year, when he graduates. He is required by law to spend a year thereafter in approved hospitals.

Selection of Students.

Is it not time that Queensland should introduce a much better standard of entry to its medical faculty than exists at the present? In the United Kingdom and the United States of America students are carefully selected after consideration of their academic achievements and their scholastic records, as judged by headmasters' reports, and an interview by a small committee of the university. An American temporarily in Queensland, who had visited several of the universities, told us of the great trouble taken to select students and of the methods in use in America.

The present system, too, is wasteful of time, effort and money. For example, in 1947 the University of Queensland admitted 166 students to the Faculty of Medicine and 53 of these failed for the year in the first year and quite a number continued on failing a second time. Many of these people would have been better occupied in a less arduous course than that of medicine and one for which they were better fitted. Their parents and they would have been saved much disappointment.

While the intake is not nearly so great as it was in the years immediately after the war, the position is still unsatisfactory. It is not suggested that mere academic capability is sufficient, as we need the best of students' capabilities, and they are many. D. H. Smyth (1946) describes them as follows:

The qualities needed in the various branches of Medicine cover a wide range and certainly include the following: intellectual capacity, integrity, ability for hard work, conscientiousness, sympathy, tact, ability to deal with people, organising ability, manual dexterity, cheerfulness, resourcefulness, ability to make decisions ... common sense, and many others. ... So wide is the field of modern Medicine and so diverse its problems that scarcely anyone would venture to suggest which of all these qualities or which combination of them is most valuable.

Those who have been members of the Faculty of Medicine for long years know that there are some who have not measured up to what is required of them, and in order that the best may be obtained, the methods that are in use in Great Britain, the United States and most other countries should be used here.

The departments that serve the needs of the Faculty of Medicine from chemistry, physics and biology in the first year, through the subjects of the intervening years to medicine, surgery, obstetrics and gynaecology in the last

years, are responsible for the teaching of the students. These departments have the duty of conserving the knowledge that has been gained through the centuries and of adding new knowledge, which simply means that they have research activities to pursue—or should have. In addition to providing for undergraduate medical training, they also have the important function of providing for the needs of graduate training and in addition, as has been stated, for research.

In order to ensure that the teaching of science subjects (in which are included anatomy, physiology and pathology) should be such as to meet the needs of the general practitioners, the university should appoint three or four practitioners who have had years of experience in practice to advise and assist the professors of these subjects on what parts of their subjects are necessary for general practitioners. Obviously we cannot give to our students who are going to be general practitioners a three or four years course in the science subjects; it is most important to decide on how much of these subjects can be reasonably undertaken so as to give undergraduates a balanced medical education.

Collings and Clark (1953) are of the following opinion:

The present day medical student is expected to absorb an immense amount of detailed knowledge, much of which bears little relation to the work he is going to do. He is the victim of rapid technical and scientific progress and the natural enthusiasms of the scientists and educators to embrace and pass on these advances in knowledge.

Review of the Curriculum Overdue.

If the matriculation has been arranged as has been set out, professors of chemistry, physics, zoology and botany "... ought to see to it"—as Professor C. G. Lambie (1953) has said—"that the materials they choose to illustrate the principles of their several sciences are drawn as far as possible from the field of medicine, but it is the principles that matter".

Professor E. C. Dodds (1949) has shown that chemistry and biochemistry can be taught to medical students in a non-mathematical manner, and he is of the following opinion:

One of the most important errors to avoid is the feeling of satisfaction that some teachers and students get through memorising formulae. ... It is most unfortunate that so many medical students, and in fact many of their biological teachers also, feel they understand the whole sterol field because they can draw a cyclopenteno-phenanthrene formula on the blackboard.

In the study of anatomy and physiology much detail can be eliminated. Professor S. Zuckerman (1947) has shown the aims at the University of Birmingham:

... to combine first the anatomical and physiological approach in every course of lectures; second by divesting the subject of much unwieldy and probably unnecessary detail, to confine dissecting room anatomy to three instead of five terms; third to devote the anatomical teaching of the 4th and 5th terms to surface and radiographic anatomy and to neurology; and fourth, to divide the 2nd M.B. examination into a first part, dealing with topographical anatomy and histology, taken at the end of the third term, and a second part, dealing mainly with physiology and functional anatomy.

Professor Lambie makes the following statement:

The use of the term "applied Physiology" in connection with the teaching of the principles of medicine as conceived here is inappropriate for the above reasons—it does not cover the field and its point of view is different. It also suggests that the subject has merely to do with the application of knowledge won in other fields of enquiry. This is far from being the case; it is in the clinical field that most of our knowledge of pathological function (and, indeed a good deal of our knowledge of normal function) has been gained. The clinical investigator is concerned with making fundamental scientific discoveries, utilising his own experimental material; he is animated by the same scientific spirit as workers in other branches of science, but in addition, he is a humanist. ... When Scientists in the pre-clinical subjects wish to take a "bite" out of clinical science they employ the rather transparent

device of prefixing the term "clinical" or "applied" to their own subject.

Professor Lambie's ideas on the early teaching of medicine are as follows:

The course on the principles of Medicine forms the main connecting link between the pre-clinical and the clinical subjects of the curriculum. It is largely concerned with abnormalities of function and the way in which altered function and structure express themselves in symptoms and signs. However, these symptoms and signs are not treated as abstractions, but are presented in the clinical context in which they arise.

One can wholeheartedly agree with him when he says that "the teaching of methods of clinical examination to beginners in medicine ought not to be given in an outpatient department where the student has before him the example of the rapid and superficial examination of patients".

The training in the principles of medicine and surgery takes place in Sydney in the fourth year of the course, and in the fifth year the students study specific diseases.

As has already been stated, Professor MacCallum said that we "... understand by professionalism, disinterested zeal for one's profession as such, so that one wishes to be as good in it as one can possibly be ...". In other words, one must have a thorough technical or technological training.

I think the practice in some quarters of decrying technical or technological training is to be deplored. The general practitioner is not being trained simply as a technician, but technical or technological training is very necessary for him, and unless he can perform in general practice all these procedures which depend upon efficient technical training, no matter how great his academic achievements, he will not be a success.

In fact, in those institutions like the New South Wales University of Technology at Sydney and the Massachusetts Institute of Technology, the necessity of a combined training is considered most important, and humanistic subjects are taken by the students. A year or so ago the professor of humanities in the Massachusetts Institute of Technology spent some time at the University of Queensland.

Training for General Practice.

In deciding on the type of training which the undergraduate requires, the universities need the help of those who have had years of experience to say what is necessary for general practice. It should be remembered that the training in hospital does not necessarily produce much of what is necessary for general practice.

It should be remembered also that training, particularly in surgery, is today in the hands of specialists in teaching hospitals, and very little attention is given to the minor surgery of everyday practice.

Dr. Richard Scott (1950), of the University of Edinburgh, who has recently spent a year in America under a Rockefeller Foundation grant, has shown how the theory and practice of training undergraduates in general practice may be carried out.

Training in general practice is also being given attention at the University of Edinburgh and at the University of Manchester. In both these places the undergraduates receive training in general practice, in which case the practice is supervised by the university. Sir John Stopford has informed me that the University of Manchester has buildings set up about a mile from the university, where this training takes place, and Professor F. A. E. Crew supervises the general practice in the University of Edinburgh.

The Early Graduates in Medicine in Queensland.

The first graduates were those of 1940, so that we now have graduates of thirteen years' standing. The great majority of those graduating in the war years proceeded on active service before entering upon general practice. Some were reserved for two, three or four years in hospitals, and from their ranks have come the first specialists from this school. Already some of them have become

clinical teachers by reason of their appointment as visiting medical officers to teaching hospitals.

It should be noted that all, or almost all, of these graduates were required to spend one year in hospital under the regulations then in force. Those who had a short time in hospital before going on war service completed the year on their return. Their hospital service and their war service, coupled with the training they received as undergraduates, have made them efficient practitioners.

What of the graduates who have qualified since the war? In the first place the numbers have been greatly increased, and there are now 500 undergraduates in the faculty. The number of graduates has correspondingly increased, and by Act of Parliament passed in Great Britain (and probably about to be passed here) they will all have to spend one year in hospital.

When the young graduates commence practice the majority of their patients have symptoms but no signs. The graduate is in an unfamiliar world. He has been used to looking for signs, and he sees them in abundance in the 20% of the population for whom the hospitals are provided. In practice, unless he has been taught, he is inclined to think that patients with symptoms and no signs are merely exaggerating their complaints or malingering. Of course, some of them are; but when he learns the art of general practice he is able to distinguish between those who are and those who are not malingering.

Collings and Clark (1953) have made the following statement:

The movement towards specialisation and the almost total domination of medical faculties by specialists has greatly intensified these trends. . . .

We further believe that it is possible and necessary to develop a new teaching medium outside the Hospitals. This should take the form of properly organised group practice, serving community needs to a much higher level than is usually possible for the individual practitioner working alone in his office.

The province of teaching must pass from the monopolistic control of the specialists and make full use of the great contribution that the General Practitioners have to offer, when they have shown that, as a group, they are capable and desirous of accepting this great responsibility.

Collings and Clark further state that the definition of a general practitioner should comprise the following:

The diagnosis of all major and minor medical and surgical conditions (except extremely complicated and rare ones). The treatment of the great majority of the medical conditions diagnosed (but only the really minor surgical conditions): Obstetrics to the level of uncomplicated deliveries, the early recognition of abnormalities and the necessarily immediate treatment of the few unpredictable but potentially catastrophic emergencies that may arise: Pediatrics to the level required for medical and surgical diagnosis and treatment: Psychiatry to the level permitting the differentiation of serious, potentially serious and mild psychoses and psychoneuroses, and permitting the treatment of the last mentioned by intelligent support, clarification and reassurance.

Early Training of Graduates in Queensland.

The training of the general practitioner on his graduation takes place in one or other of the teaching hospitals in Brisbane or in one of the country hospitals.

The greater number of graduates are trained in the large Brisbane Hospital, where about 40 are trained each year. No serious attempt is made to consult the desires of graduates on their plans for their medical careers. It is quite impossible in the twelve months to arrange a course that will adequately prepare a student for general practice.

Instead of his year in hospital being planned so that he will have an opportunity of gaining experience in the conditions that first-year resident medical officers should rightly be expected to encounter in general practice, he will in many cases not receive training in obstetrics, diseases of women, diseases of children, psychiatry and anaesthesia—all of which are most useful for general practice. On the other hand, he has to work as a house

surgeon and house physician, undertaking duties which in many cases could be performed much better by those aspiring to be specialists of one sort or another. His education as a graduate is an incidental and secondary consideration.

It would appear that the function of the first-year resident medical officer is to serve the hospital. Is not a cheap form of labour thus being exploited? These young men, having finished a very arduous course, should expect a forty-hour week and ample time left over for study and recreation. This is not the case at present, and there are a number of instances of breakdown in a graduate's health through overwork. This is a matter which should receive urgent attention from the authorities.

When the young graduate goes into practice in the city or in a country town he undertakes work that, according to his conscience, he should or should not undertake. This is particularly so in the case of surgery, and there are many complaints about the young graduate engaging in surgery that is beyond his capacity.

Of course, it is true that the great majority of practitioners learnt by trial and error; but this is a state of affairs that had to be endured in the times before Queensland had a medical school. It should no longer be tolerated. Those who are going to undertake routine major surgery should be better qualified, as will be explained later, than those who have just finished their training.

Preventive Medicine.

It should not be forgotten that the general practitioner has the duty of giving advice on how to prevent illness, and must be ever on the alert to detect it at the earliest possible moment and so make the cure of his patients more certain. However, he cannot do this unless people come to him for advice.

Fremont-Smith (1953) makes this statement:

. . . I did not know how to recognise early disease in the early days of my practice if it ever appeared and I was not really interested. What I wanted then were sick people who would get well and be grateful or cases of advanced disease with good abnormal physical signs for differential diagnosis and teaching purposes.

The so-called "well" person seeking to avoid further illness, or to discover early evidence of trouble already present, usually received but superficial attention from the busy physician.

Fremont-Smith set a time apart for examination of people who were well, and found that among 100 "well" patients whom he examined, there were five cases of cancer, one of myxoedema and 17 of obesity and hypertension. He recognized that periodic examination should be undertaken in a community as the only method of detecting disease early.

There may be some objection to the conducting of examinations on "well" patients by practitioners; but if the examinations are carried out by people appointed by the government who are concerned only with examinations and not with treatment, and if the whole system is a voluntary system, people may come in time to accept the procedure as a routine part of their lives.

We have seen in the case of tuberculosis very many people coming voluntarily for X-ray examination and Mantoux testing. No doubt the same system could be applied to diabetics. Professor C. H. Best, when he was here, told us that there were many more diabetics than were under treatment.

A system of periodic examinations would overcome this. If these people were examined by Commonwealth medical officers there would be no question of any pecuniary gain to any such officers, who would refer patients to practitioners according to their needs.

The Training of Specialists.

What of those graduates who remain for two or three or more years in hospitals? Most of them are going to become specialists after taking higher degrees or diplomas. They are then entitled to call themselves specialists in Queensland.

In many instances they are not nearly so well informed, either about patients or about their diseases, as many general practitioners of ten or more years' standing, and in some cases these people have become specialists on obtaining a post-graduate diploma in six months.

The legal enactment that established a list of specialists was a step in the right direction; but unfortunately there was nothing in the Act that set up this list of specialists to ensure that a doctor should be well trained, other than the provision that he should have a higher degree or diploma.

Some of those diplomas can be obtained in six months and the holders can then be registered as specialists, while the only knowledge they have obtained may be largely academic. This is a weakness that ought to be remedied as soon as possible. Nobody should be allowed to be registered as a specialist until he has spent five years at least in practice after graduation.

The Need for Better Facilities for Graduate Training.

The time has come when graduate medical education should be much better organized than at present. The greatest difficulty in bringing this about is the provision of the necessary hospital facilities and appointments for graduates for the purpose of giving them the necessary training. The State should pass enabling legislation to ensure that the university and the hospitals should cooperate in this important work.

Those members of the profession who worked to establish a school of medicine in Queensland had to wait twenty-three years before the school was established. We do not want to wait another twenty-three years before there is adequate provision for graduate medical training. We should do well to follow the lead given by the Royal Australasian College of Surgeons and insist that those who are going to specialize should serve part of their time in apprenticeship, as it were, to those who have already qualified as specialists.

At the present time many of our graduates have to go abroad to get this training in the United Kingdom and the United States of America, and very little has been done to meet the needs of Queensland's own graduates. In the years gone by surgeons were first general practitioners, and on many occasions they had to perform their first major operation alone. It is all right in the case of those who are born surgeons; but in other cases surgical skill could be gained only at the expense of their patients. It would be much better that they should perform their first major operation under the direction of well-qualified surgeons.

In a large State like Queensland we need surgeons who are able to deal with the vast majority of surgical conditions, and there is a great need to see that our own Queensland graduates are better trained than those of fifteen years or more ago.

It should be emphasized that all students should have an opportunity of participating in general practice during their undergraduate training, so that they can get an understanding of the environmental and human relations of patients.

In the metropolitan hospitals graduates receive only eight weeks' training in surgery, and there is some doubt as to whether the General Medical Council will grant them reciprocity for practice in the United Kingdom.

As Collings and Clark (1953) state:

It is time for the role bestowed on the General Practitioner-Specialist as the result of practical necessity to be rationally considered and sensibly equated with the achievements and future possibilities of a more formal and better controlled specialist service.

As in Australia:

In the early part of this century many became, through self-acquired postgraduate training and experience, qualified Specialists (of the day).

There are some practical difficulties to be solved before this can be achieved. Disease is no respecter of geography, and in a large State like Queensland we should devise a

method whereby specialists may travel by air to wherever they are needed to assist a general practitioner surgeon. All sick people cannot be transferred to large centres, so it is a case of "Mohammed going to the mountain".

It should be realized that three types of surgery are practised in Queensland. One is purely minor surgery, which is carried on in most general practices. The second is routine surgery. The bachelor of surgery degree should not be awarded on graduation, but only the degree of bachelor of medicine. The general practitioner surgeon should be required to take a bachelor of surgery degree, and should be trained as a graduate in those procedures which are part of everyday surgery by gaining the necessary experience in a hospital working under a qualified surgeon. The training should extend over a period of two years. The third type of surgery is specialist surgery, and specialist surgeons should have the highest qualification of all.

All teaching hospitals should find a place for some general practitioner surgeons on their staff. They are very well able to carry out much of the work done in a university teaching hospital, and they would be capable of carrying on much of the teaching of students who are to become general practitioners.

Two effects will follow these suggested changes. A much better educated type of practitioner will emerge, and if the university is brought into the training and the hospitals throughout the State are made places where graduate instruction can be given by the university professors and others, the hospitals will gain immeasurably by getting a more efficient staff. The practice of allowing inexperienced resident medical officers to attend to the major ills of the community and to expect them to make important decisions should cease immediately.

Economic and Social Conditions.

The social changes that have occurred are having a profound effect on general practice. Thirty years or more ago it was easier for a graduate to commence practice as an individual than it is today. He employed a nurse or managed with the help in his home. In the latter event the practitioner needed to have someone to assist with the housework, and in addition a nurse for his children, if he had any. Costs were on a lower scale then and help was readily available.

Nowadays the position is quite different. The changing type of practice has necessitated his having a nurse, who draws a basic wage of somewhere about £10 per week, and to help his wife with the house and children he has to rely for the most part on washing machines, washing-up machines and the like. The best that he can do is to provide somebody who is able to do his washing and cleaning. The cost of these services has very much increased, so it is no wonder that the fees of the general practitioner have to be increased.

Today, in order to reduce the costs of practice, practitioners are grouping together in twos, threes, fours or more, and sharing the various expenses. The majority of those in the practice live in some place other than where the surgery is situated.

By these means the costs are greatly reduced and the doctor's wife is freed from much of the work she used to perform—in some instances, freed from slavery.

It will be a good thing if this becomes the accepted system of general practice. It can provide a twenty-four hour service if there are sufficient members in each group. It allows for holidays and a period of post-graduate study. It can provide for decentralization of practice with pathological and X-ray services at the periphery in addition to the centre. Last, but not least, the patients should get the benefit of a reduction in the cost of service.

Conclusion.

It should not be thought that these opinions are those of the Faculty of Medicine of the University of Queensland. They may or may not be; I cannot say. They are the opinions that are held as the result of much reading, discussion and experience. This experience has been gained

in general practice, in practice as a specialist, and in later years in three departments of the university—namely, those of anatomy, of surgery, and of social and tropical medicine.

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THE MODERN CONCEPT OF PULMONARY TUBERCULOSIS AND PREGNANCY.

By A. G. McMANIS, M.R.C.P., M.R.A.C.P.,
 Sydney.

THE original stimulus to write this paper was provided by the desire to report two cases of lobectomy for pulmonary tuberculosis performed during pregnancy. However, it was considered opportune to comment also on the present clinical attitude to the relationship between pulmonary tuberculosis and pregnancy. As medical officer to the Eva Hordern Hospital for tuberculous mothers, it is apparent to me that such a statement is timely.

Over the years there has been a remarkable change in medical opinion on this subject. This, of course, is widely known, but it is apparent that there are obstetricians and general practitioners who still hold the views that were generally taught in the early decades of this century.

Former Opinion.

History records that Hippocrates and Galen advocated pregnancy as a treatment for phthisis, because their clinical observations had led them to the belief that the course of the latter was favourably influenced by gestation. This attitude was held by their successors, and remained unchallenged for many centuries. Indeed, it was not until the middle of the nineteenth century that it was challenged. A complete reversal of opinion occurred, and, as a consequence, it was generally held that the influence of pregnancy on pulmonary tuberculosis was entirely bad, and that every pregnancy in a tuberculous woman should be terminated as soon as it was discovered.

In 1926 the eminent London chest physician Sir Robert Young quoted a picturesque aphorism: "For the virgin no marriage, for the married no pregnancy, for the pregnant no confinement, for the mother no suckling."

Modern Opinion.

Hill (1928) studied the pregnancies of 349 women who suffered from active tuberculosis, and concluded that pregnancy had no appreciable effect on the course of the disease. Her conclusions were based on a short follow-up period, but were a challenge to generally accepted opinion at that time.

Brooks (1940) remarked that "scarcely any accurate scientific data exist, by which the hypothetical effect of pregnancy on pulmonary tuberculosis may be evaluated". However, evidence has been steadily accumulating which would indicate that pregnancy in general has no dramatic effect on the course of the disease.

Turner (1950) published his observations on 718 pregnancies in 534 different tuberculous women; many of them were followed for periods up to ten years after pregnancy. He summarizes his results in quiescent tuberculosis by stating that "it is thus evident that the woman with quiescent tuberculosis, who becomes pregnant, or wishes to become pregnant, may be reassured, and no question of terminating the pregnancy should arise".

Turner compares the ten-year survival rate of his patients with active tuberculosis with other studies, and concludes as follows:

There is thus no evidence in this series that pregnancy adversely affects the group prognosis in active tuberculosis. This does not, however, mean that in individual women the prognosis may not be worsened, just as in others the pregnancy may exert a beneficial effect on the tuberculosis. I feel sure that in a minority pregnancy is a direct cause of deterioration, and that in another and probably a larger minority the effects of pregnancy, physically and psychologically, are beneficial, but that in the majority pregnancy has no obvious influence on the tuberculous process.

Turner found that the two periods of pregnancy at which factors arising from pregnancy might exert an unfavourable influence, were the first four months, and the time immediately following parturition. To explain these findings he propounded the theory that endocrine factors might be responsible for them.

Cohen *et alii* (1952) review the literature and state that the view emerges that child-bearing does not seriously affect the long course of tuberculosis, provided that the disease is adequately treated. Their own study is based on 401 full-term pregnancies in 149 tuberculous women. All patients were followed for a minimum period of five years, the maximum period of study being twenty years. They conclude that the evidence obtained from this study can incriminate neither the child-bearing incident, nor other specific factors related to pregnancy, as potentially dangerous for tuberculous women. They compare groups of women with and without pregnancies, and find that the end results in both groups are "remarkably similar". It is their belief that the best management of the tuberculous mother is to carry out whatever treatment is indicated for the best care of the tuberculosis *per se*, regardless of the pregnancy.

Edge (1952) studied the course of tuberculosis in two groups of tuberculous women who became pregnant; in one group the patients were allowed to proceed to full term, and in the other the pregnancies were terminated surgically. He found that the proportions of patients whose condition was subsequently deteriorated, unchanged or improved in each group were "strikingly similar". He states that "from the evidence presented in this series there is no indication for therapeutic abortion, as the outcome seems to be similar, whether the pregnancy is terminated or not". He also states that there is no evidence that pregnancy, whether terminated or allowed to continue, had any definite effect on the course of the disease.

The Eva Hordern Hospital.

The Eva Hordern Hospital is a 17-bed hospital, conducted by the Australian Red Cross Society, for the care of tuberculous women who are pregnant. The general management of the patients is based on the principle that the tuberculosis is treated as it would be if the patient was not pregnant. Naturally the presence of the pregnancy does necessitate some modifications, but these are not of major importance. The ante-natal care is carried out by visiting medical officers from the various obstetric hospitals. When the patient comes into labour she is sent to the hospital concerned, and returns to the Eva Hordern Hospital about a week after delivery.

Bed rest, as always, is the basis of all treatment. Streptomycin and PAS may be given if indicated. It was once feared that streptomycin might harm the fetus, but this is not so. Artificial pneumothorax can be used if indicated; even patients with bilateral pneumothoraces are not disturbed by pregnancy.

Reports of Cases.

CASE I.—Mrs. S., aged thirty-three years, had two children. She had had pleurisy at the age of eighteen years, and had a brother who died of pulmonary tuberculosis. In January, 1950, she was radiologically examined by the Anti-Tuberculosis Association Clinic, because of symptoms of weakness and nervousness. This X-ray film revealed an area of infiltration in the upper lobe of the left lung. A gastric lavage was performed and a negative result was obtained on attempted culture. Subsequent X-ray examinations in March and April of that year did not reveal any change in the lesion.

An X-ray film taken on October 3, 1951, revealed that the lesion, previously present, had undergone a change. It had become larger and more rounded and discrete in appearance. At that time the patient was pregnant, her last menstrual period having occurred on July 20, 1951.

She was admitted to the Eva Hordern Hospital on October 22. At that time there were no symptoms referable to the respiratory system, and physical examination of the chest revealed no abnormality. The Mantoux test produced a positive result with a one in 1000 dilution of old tuberculin. A gastric lavage was performed and cultural examination of the material gave negative results. The erythrocyte sedimentation rate was 12 millimetres in one hour (Westergren). A tomographic examination revealed a rounded homogenous lesion situated in the upper lobe of the left lung.

The radiological behaviour of this lesion indicated that it was, almost certainly, tuberculous. The fact that it was "solid" and unstable indicated that it would be best treated by resection. It was decided to perform this operation during the pregnancy. At the fifth month she was transferred to Bodington Chest Hospital. On January 11 a bronchoscopic examination was performed, with normal findings, and on January 17 a left upper lobectomy was performed. Except for some post-operative vomiting, there were no ill effects from the operation.

When she returned to Eva Hordern Hospital on February 8 the lower lobe of the left lung completely filled the left side of her chest. On February 24 there was some bright bleeding *per vaginam*, but no pain. The Women's Hospital, Crown Street, were looking after the pregnancy, and she was transferred there for ten days for observation. However, no cause for the bleeding was found. The remainder of the pregnancy was uneventful, and she was confined of a living female infant on May 5.

The patient was discharged from the Eva Hordern Hospital on July 29; at this time she felt well, and X-ray examination revealed no evidence of disease. Her erythrocyte sedimentation rate was four millimetres in one hour (Westergren). She has been examined regularly since her discharge from hospital, and has remained very well. The X-ray appearances have not changed.

Examination of the specimen removed at operation revealed a blocked cavity in the posterior segment of the upper lobe of the left lung about three centimetres in diameter. The draining bronchus was stenosed, but a fine probe could be passed into the cavity, which was full of caseous material.

CASE II.—Mrs. H., aged twenty years, was a *primipara* and had an uncle who suffered from pulmonary tuberculosis. She had a history of asthma since the age of ten years. Her last menstrual period had occurred on December 19, 1951, and a routine X-ray film taken at the Royal North Shore Hospital of Sydney, because of the pregnancy, revealed a lesion. This lesion was a rounded area of opacity in the right lower zone. There were no symptoms referable to the respiratory system, and physical examination of the chest revealed no abnormality.

A tomogram was taken, and this showed a solid round opacity with a peripheral area of cavitation above and laterally. The erythrocyte sedimentation rate was 12 millimetres in one hour (Westergren). Gastric lavage was performed and *Mycobacterium tuberculosis* was grown on culture from the material obtained. The patient was admitted to the Eva Hordern Hospital on April 28.

On May 27 she had slight bleeding *per vaginam* together with lower abdominal pain. This settled down, and did not cause any concern to the obstetrician from the Royal North Shore Hospital who was attending her.

It was considered that surgical resection was the correct treatment for the lung lesion, and when she was six months pregnant she was transferred to Bodington Chest Hospital. An X-ray film taken just prior to operation showed that the lesion had cavitated.

On June 19 a right lower lobectomy was performed; a bronchoscopic examination just prior to operation failed to reveal any abnormality. The post-operative period was uneventful, and on July 1 she was returned to the Eva Hordern Hospital. At this time her X-ray film revealed that the upper and middle lobes of the right lung completely filled the right side of her chest.

The remainder of the pregnancy was uneventful, and on September 21 she was confined of a living female infant. After her confinement she began to have a recurrence of asthma. She was discharged from the Eva Hordern Hospital on December 6, when her erythrocyte sedimentation rate was two millimetres in one hour (Westergren).

Since her discharge from hospital, she has been examined regularly, and has had further asthmatic attacks, but has been well otherwise. The X-ray appearances have remained unchanged.

Examination of the operation specimen revealed a thick-walled cavity in the lateral basal segment, partly filled with caseous material and communicating with a draining bronchus of the third generation. Microscopic examination of the cavity wall revealed caseation and tuberculous granulation tissue. The lesion was sharply circumscribed, and no surrounding fibrous tissue could be seen. An adjacent lymph node contained tuberculous foci.

Treatment During Pregnancy.

It is extremely important that adequate treatment of the tuberculosis should be carried out during the pregnancy. It is in this respect that the Eva Hordern Hospital provides such an excellent contribution to the tuberculosis service in this State, for it ensures that such treatment is available for all tuberculous mothers.

Danger Periods.

It is only those patients whose lesions are considered active who are admitted to hospital. Those with inactive lesions are kept under close observation as out-patients. Particular care is taken during what are considered to be the danger periods.

We have found that these danger periods are similar to those found by Turner—namely, early in the pregnancy and in the period immediately after delivery. In many of our cases the reactivation occurred so early in the pregnancy that I believe the association with the pregnancy could have been missed unless it had been particularly looked for.

Breast Feeding.

It is usually in the best interests of both mother and child for the child to be breast fed. Therefore, if breast-feeding is harmless, it is wrong to prevent it. It is generally believed that if the patients' condition is stable and they are non-infectious, it is safe for them to feed their babies. We have not seen any harm come from this practice.

Chest X-Ray Examination During Pregnancy.

It is fairly universal practice to have an X-ray film of the chest taken during every pregnancy, but there are some private practitioners who do not do so. Not only is it important to know whether the mother has tuberculosis or not, but it may also be the means of preventing the child from developing tuberculosis meningitis.

Surgery During Pregnancy.

The reasons for advising surgical treatment during the pregnancy were twofold. When the time for surgical treatment arrives, the sooner it is carried out the better. There is always present the danger that the disease may extend and delay operation for some considerable time, or even make it impossible altogether. The second consideration is that the patient will be in hospital for a shorter time after the baby is born, and will be able to look after it sooner.

Pregnancy Subsequent to Surgery.

There has been one patient who had undergone pneumonectomy for tuberculosis approximately twelve months prior to her pregnancy. This patient had twins, and negotiated her pregnancy and labour without any difficulty. There have been three patients who had previously had thoracoplasties, and went through their pregnancies without any harmful effects.

Obstetrical Facts.

It is not the purpose of this paper to discuss the obstetrical aspect of these cases; but the presence of pulmonary tuberculosis has not had any material effect on the pregnancy. It is recorded that there have been three sets of twins, and one Caesarean section, without any effect on the pulmonary disease.

Termination of Pregnancy.

It would appear from the evidence produced that it is difficult to justify the termination of pregnancy for pulmonary tuberculosis. Certainly in quiescent cases the question should not even arise. In active cases, there is evidence to show that the end result is the same, whether the pregnancy is terminated or not. Also interruption of the pregnancy does not alter the management of the pulmonary disease. For, if active disease is present, it will be treated in the same manner whether the pregnancy is allowed to continue or is terminated.

Summary.

The fluctuations in medical opinion on the relationship of pregnancy and pulmonary tuberculosis are traced. Some important recent papers on this subject are reviewed.

Experience at the Eva Hordern Hospital for tuberculous mothers is quoted. Two cases of lobectomy for pulmonary tuberculosis during pregnancy are reported.

The management of patients with tuberculosis during pregnancy is discussed, including the position of surgery.

The danger periods associated with pregnancy, breast-feeding, X-ray examination during pregnancy and the question of termination of pregnancy are discussed.

Acknowledgements.

Dr. Ian Monk performed both the operations reported in this paper. My sincere thanks are due to him for his helpful advice and constructive criticism in the preparation of this paper.

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FURTHER EXPERIENCES WITH THE USE OF INTENSITY-TIME CURVES IN THE ELECTRO-DIAGNOSIS OF NERVE LESIONS.¹

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It is just twelve months since we began plotting intensity-time curves (I-T curves) as a supplementary method to classical galvanic-faradic testing in the electro-diagnosis of nerve lesions, and while we still have much to

learn, I thought that it might be of interest to illustrate our experiences with this method by reporting briefly some case histories.

Our preliminary report on this method was given at the last annual meeting of the Australian Association of Physical Medicine held in Melbourne in August, 1952, and further experience since then has only confirmed our enthusiasm for this valuable addition to the methods of electro-diagnosis.

The equipment necessary is simple and inexpensive; the technique of carrying out the test is fairly easily acquired by any operator of experience; and, while the interpretation of the plotted curves is not always easy, we are now firmly convinced that in difficult diagnostic problems, and in all cases of serial testing in following up progress in nerve lesions, it is essential to supplement the old classical galvanic-faradic test with the use of I-T curves.

Electromyography is an alternative method, and reference to this will be made later; but we do feel strongly that in these types of case the galvanic-faradic test alone is no longer adequate for a reliable and satisfactory report on nerve and muscle function. Our feeling in this matter is fully corroborated by the experience in overseas clinics, many of which have investigated the use of I-T curves in electro-diagnosis for several years, and have now adopted their use in routine testing of nerve lesions.

In the type of instrument we employ—a "Newton Victor Electronic Stimulator" of constant voltage type—we determine the minimum voltage that will evoke a contraction of muscle, using square wave pulses of galvanic current, at different periods of flow, ranging from 100 milliseconds down to 0.02 millisecond.

The graph in Figure 1 shows normal curves, and curves characteristic of complete reaction of degeneration—that is, complete lesions of the lower motor neuron. The normal curve is flat, and rises steeply only at the extreme left-hand side—that is, at the short duration pulses. It is a continuous curve; there is no rise of current from 100 to 10 milliseconds; the current necessary at one millisecond is less than twice the rheobase, and the chronaxie is less than 0.1 millisecond.

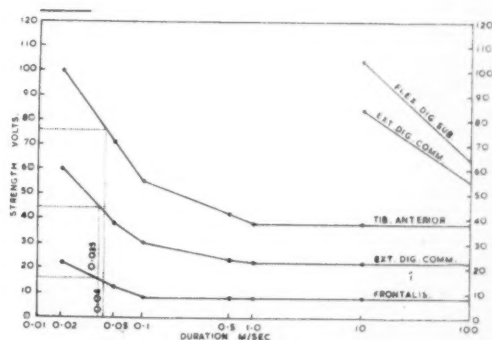


FIGURE 1.

The rheobase usually lies between 10 and 30 volts, but there is considerable variation in different muscles and in different patients. It is less in proximal and face muscles, and higher in distal and leg muscles.

In a complete lesion, with complete reaction of degeneration, the curve is again a continuous one, but is displaced upwards and to the right, with a lack of response at short time flows, and a high chronaxie. Between these two extremes lie the intermediate curves of partial reaction of degeneration (found in partial lesions, in the development of progressive lesions, and during recovery from complete lesions), and it is here, of course, that we encounter difficulties.

It is noteworthy that the experimental work of Pollock *et alii* showed that degeneration—with the accompanying

¹ Read at a meeting of the Australian Association of Physical Medicine, Sydney, April, 1953.

abnormalities in electrical responses—might not become complete for up to two months after the lesion. This is important, because a discontinuous curve is found only during the development of degeneration, or during regeneration. In interpreting a curve the time lapse since the lesion is therefore important. A discontinuous curve is definite evidence of regeneration and recovery, provided that the lesion is not in the stage of development of degeneration.

The value of chronaxie in itself must be viewed with caution. A very high chronaxie is evidence of reaction of degeneration, but a lowering of chronaxie is not in itself certain evidence of improvement. In other words, we must look at the curve as a whole, and not merely concentrate on one isolated point on the curve.

The position becomes clearer if we look at Figure II, which illustrates the curves obtained during serial testing of a patient recovering from a complete lesion (Case I).

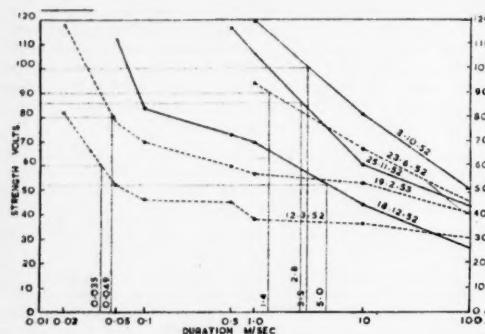


FIGURE II.

Reports of Cases.

CASE I.—J.B., a male patient, aged twenty-four years, on May 16, 1952, received a stab wound of the left elbow. The severed radial nerve was sutured. The *extensor digitorum communis* was chosen for study, and no voluntary power was present.

On June 23 the classical test produced no faradic response and a sluggish galvanic response; the anodal closure contraction was greater than the kathode closure contraction; reaction of degeneration was present. An I-T curve confirmed the reaction of degeneration. The curve was displaced upwards and to the right; there was a lack of response below one millisecond, and high chronaxie (1.4).

On October 2 the I-T curve was a little steeper, and chronaxie had increased to 3.5. This apparent slight change for the worse is not the bad prognostic omen it may appear, since the previous curve on June 23 was obtained only five weeks from the lesion, and the experimental work of Pollock *et alii* showed that two months or more might be required before degeneration and the accompanying abnormalities in electrical test results became complete. This is therefore a good illustration of the importance in studying curves of taking into account the time lapse since the lesion.

On November 25 the I-T curve showed definite improvement, and made it possible to give a good prognosis. There was now a response at 0.5 millisecond, and the discontinuity in the curve indicated that regeneration was taking place. Chronaxie was slightly reduced to 2.8 milliseconds.

On December 18 voluntary power was beginning to appear; this had been predicted in the curve one month earlier, and overseas reports agree that recovery can often be anticipated from the curve about six weeks before there is clinical evidence of improvement. The I-T curve shows vast improvement; it is displaced down and to the left, discontinuity indicating regeneration, and there is now a response at 0.05 millisecond. Chronaxie has risen to five milliseconds—another instance of the fallacy of relying on chronaxie alone.

On February 19 the curve approached nearer to normal, there now being a response at 0.02 millisecond, and chronaxie was now less than 0.05 millisecond—within normal limits.

On March 12 fair voluntary power was present. The curve was very close to normal, though discontinuity showed that

regeneration was still taking place. Chronaxie was then 0.035 millisecond.

This case illustrates well the changes that occur in the I-T curves during recovery from a complete lesion.

CASE II.—A.L., a male patient, aged twenty-one years, on April 17, 1952, fractured the mid-shaft of his left humerus; this was followed by radial and median nerve palsy. On May 25 complete radial palsy, and almost complete median palsy were present. Study was concentrated upon the *flexor digitorum sublimis* for median supply, and upon the *extensor digitorum communis* for radial supply. (Figure III.) The classical tests were applied. The radial supply gave no faradic response and a sluggish galvanic response, the anodal closure contraction being greater than the kathode closure contraction; reaction of degeneration was present. The median supply gave a weak faradic and a sluggish galvanic response; the polar formula was reversed. The classical tests therefore revealed a slight lesion in the median nerve, and a pronounced lesion in the radial nerve. I-T curves confirmed this, in more detail. The curve for the

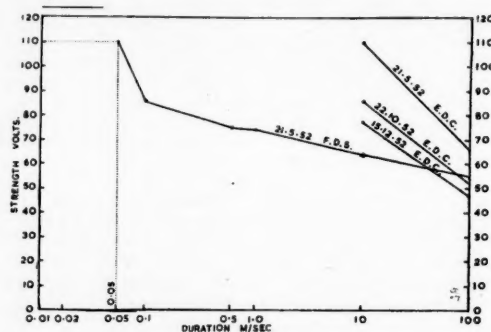


FIGURE III.

radial nerve was displaced up and to the right, with no response below 10 milliseconds, and demonstrated beyond all doubt the presence of a complete lesion. The curve for the median supply showed a rise of current from 100 to 10 milliseconds, demonstrating that there was a lesion; but the contour of the curve was not far from normal, and this, together with the presence of responses at short period flows and low chronaxie (0.05 millisecond), showed that the lesion was only slight. A good prognosis was therefore given for the median supply, but a guarded prognosis for the radial supply. The curve for the median supply also was discontinuous, indicating that regeneration was taking place. The high rheobase, and therefore the high placement of the curve, was a good sign rather than the reverse. Voluntary power rapidly returned in the median supply, but there was no sign of clinical recovery in the radial supply, and further curves, as shown on October 22 and again on December 15, indicated that the lesion was still complete, with no sign of recovery.

Surgical exploration was performed on March 5, 1953, when it was found that there was a large gap in the radial nerve, with atrophy of the distal portion.

CASE III.—G.T., a male patient, aged fifty-three years, in October, 1951, developed a radial nerve lesion after an injection of penicillin into the arm. Complete paralysis persisted. On February 22, 1952, exploration revealed a nodular appearance and some fibrosis. Nerve suture was performed. The *extensor digitorum communis* was chosen to study progress. (Figure IV.)

On August 19 classical tests still showed reaction of degeneration; there was no faradic response, the galvanic response was sluggish, and the polar formula was reversed. In other words, this test showed no evidence of recovery, although there was a flicker of voluntary movement. However, the I-T curve showed definite evidence of recovery. The contour of the curve, and the rise in current from 100 to 10 milliseconds, demonstrated that there was still a lesion, but the presence of a response as far down as 0.05 millisecond was a good sign, and the discontinuity was evidence of regeneration. Chronaxie is still high at over one millisecond. The high rheobase of 52 volts was a good sign.

On December 10 voluntary power was appearing. The I-T curve showed definite improvement, by displacement

down and to the left; the response occurred now at 0.05 millisecond, and there was a reduction in chronaxie to 0.52 millisecond.

On February 23, 1953, together with clinical improvement, there was a return of the I-T curve towards normal. It was displaced further down and to the left, being almost horizontal down to one millisecond, and chronaxie was now reduced to 0.14 millisecond.

CASE IV.—Mrs. R.M., aged thirty-five years, after the removal of a tuberculous cervical gland in November, 1952, developed right trapezius palsy. On January 23, 1953, the classical test produced no faradic response and a sluggish galvanic response, the anodal closure contraction being greater than the cathode closure contraction. The I-T curve (Figure V) was a little outside normal limits, but the rise in

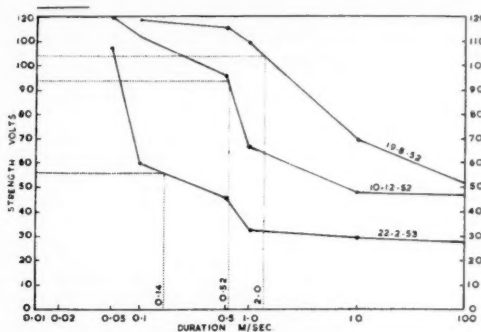


FIGURE IV.

current, slight though it was (from 100 to 10 milliseconds) together with a chronaxie of 0.15 millisecond, suggested a partial lesion. Nevertheless, on the curve alone it would leave a little doubt, and it is here that the classical test is a great check on the curve, for the galvanic-faradic test shows the presence of reaction of degeneration beyond all doubt. Although it does this, it does not give any idea of the extent of the lesion, and it is only by looking at the I-T curve that we are able to determine that the lesion is only partial, and give a correspondingly hopeful prognosis.

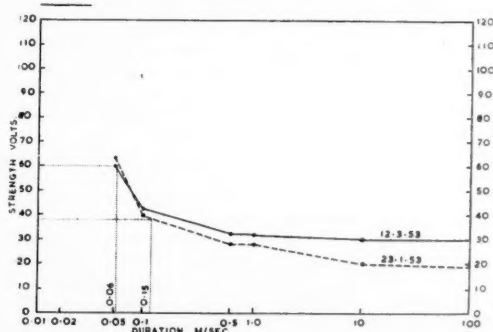


FIGURE V.

On March 12 there appeared to be a slight clinical improvement, though this was a little in doubt. Classical testing still showed no faradic response, and the galvanic response was still sluggish, but the cathode closure contraction was now greater than the anodal closure contraction. The I-T curve showed definite improvement; there was now no rise in current from 100 to 10 milliseconds, the curve was more horizontal from 0.5 millisecond onwards, and the chronaxie was reduced to 0.06 millisecond—within the limits of normal.

This case is a good illustration of the value of using both the classical test and the I-T curve.

CASE V.—H.B., a male patient, aged thirty-one years, was examined on December 18, 1952. Three months earlier, after a fall, he had developed low-back pain and pain in his right leg. The pain gradually subsided, but he then noticed right

foot drop. Clinical examination disclosed weakness (power "3") in the dorsiflexors of the right ankle, and in the peroneal muscles. He was referred to us for opinion about a lower motor neuron lesion. Classical tests produced normal faradic and galvanic responses, and no evidence of reaction of degeneration. (Figure VI.)

The I-T curves were interesting. The curve for the *peroneus longus* was normal, but the curves for the *extensor digitorum longus* and the *tibialis anterior* both showed evidence of reaction of degeneration. In each case there was a rise in current from 100 to 10 milliseconds, and the chronaxie was well above normal limits. The *extensor digitorum* had a chronaxie of 0.4 millisecond, the *tibialis anterior* one of 20 milliseconds. Discontinuity in the curves is evidence of regeneration.

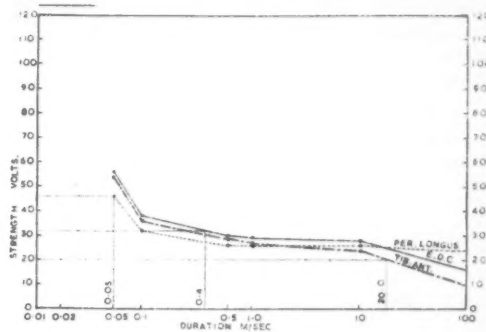


FIGURE VI.

In this case the classical test failed to disclose evidence of reaction of degeneration, but the curves not only confirmed the presence of reaction of degeneration and the diagnosis of a lower neuron lesion, but also enabled us to give a good prognosis. This patient was given physiotherapy, and discharged from hospital on March 2, 1953, with full power and no disability.

CASE VI.—G.S., a male patient, aged sixty-four years, dislocated his left shoulder on December 11, 1952. This accident was followed by a deltoid palsy. On January 5, 1953, left

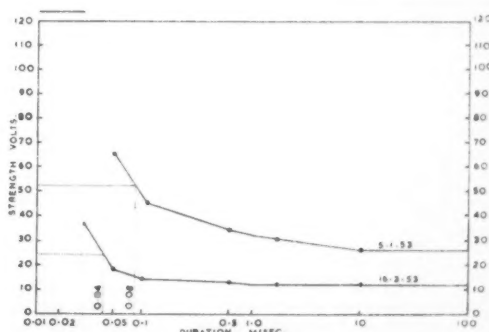


FIGURE VII.

deltoid paresis was present (power "2"). The I-T curve is little outside normal limits, though the chronaxie is 0.08 millisecond—a little on the high side, but not outside the range of normal variation. (Figure VII.) Classical tests produced no faradic response, and a sluggish galvanic response, with reversal of the polar ratio. Here the classical test detected the presence of reaction of degeneration, whilst the I-T curve alone left us in doubt. However, it was the curve alone which enabled us to say that the lesion was only partial, with a good prognosis.

The patient was given efficient physiotherapy, and on March 16 had improved considerably, power now being "4". An I-T curve taken on this date shows a return to a perfectly normal contour, with a reduction in chronaxie to 0.04 millisecond.

Discussion.

I feel sure that these few examples alone are sufficient to show the tremendous advantage of supplementing classical galvanic-faradic testing with the use of I-T curves. This latter and more recent method gives a much more accurate indication of the extent of the lesion, and of prognosis, and in serial testing in following up the progress of nerve lesions it is far superior.

However, let me sound a note of warning. The I-T curve in itself is not infallible—the interpretation of the curves is not always simple and definite; moreover, the range of normal variation is such that it is possible to find in a case of partial lesion an I-T curve which, even though it may not appear completely normal, is nevertheless within the range of normal variations. In other words, it may not be possible to detect a partial lesion on the I-T curve alone in all cases.

This is no reason for looking on the test with doubting eyes; a normal electrocardiogram is not certain evidence of a normal heart, but we use electrocardiograms every day. Fallacies may therefore occur, but they will be minimized if in every case the I-T curve is considered together with the results of classical testing and clinical examination. We have seen examples of this in the cases shown. We should not depend solely on an I-T curve for diagnosis, any more than we depend solely on an electrocardiogram or, for that matter, an X-ray examination. The fact remains that here is a valuable adjunct to the classical method of testing, and we all know how sorely this is needed.

Many questions will doubtless occur to you, and the first—which has already been put to me—is this: Ignoring altogether the problem of interpretation, can we rely upon the curve obtained as being correct? This is a vital question, and one which must be answered satisfactorily if any reliance is to be placed upon the test. It would appear at first sight that in such a delicate test great variations might occur in the curve obtained, particularly if it was carried out by different operators, but this is not so.

It does not require a great deal of experience in the method for any careful and experienced operator to obtain reasonably consistent curves, provided certain precautions are observed. These are as follows.

1. Electrode placement. Good skin contact must be ensured, and it is of the utmost importance that the electrodes be fixed in position, and not even touched or altered in any way from start to finish of the test. Bipolar technique is preferable when possible, because it minimizes the risk of current spread to neighbouring muscles, and it is our practice before fixing the active electrode to use a fairly strong current at 100 milliseconds flow and to move the active electrode about until the best site is found for stimulation. Once this is determined, the electrode is fixed in position.

2. The use of both sight and touch. The operator must always be certain that he obtains a definite contraction, and that this occurs in the muscle being tested, and is not due to contraction of nearby muscles stimulated by current spread.

This in no way ignores the fact that the more experienced and careful the operator, the more consistent the results. Different operators—provided they are careful and experienced—will obtain closely similar curves, and this for two reasons. Firstly, at any one given period of flow, as the current is gradually increased, it will be found that the current value required to evoke a contraction is fairly critical. An increase of only one or two volts is sufficient to change response from no contraction to a definite contraction. Secondly, it is true that some operators are more sensitive in detecting a response, and this is responsible for individual variations. However, these differences will affect only the rheobase and the placement level of the curve, which is of minor importance. They will not affect the contour of the curve, or the chronaxie.

The next query that will be raised—particularly by our members who have recently returned from overseas—concerns the apparent great variation in the types of instrument available for the preparation of I-T curves. Each man seems to use a different type of machine. I myself have encountered this problem in overseas correspondence about this aspect.

However, the position is not so confusing as it may appear. There are two types of instrument, constant voltage and constant current, and while the curves obtained vary a little in detail, principles are unaffected. The main difference in the two types is in the value obtained for chronaxie. In the constant current machine the value is about ten times that obtained in the constant voltage type; for example, normal chronaxie in the constant current method is below one millisecond, whereas in the constant voltage method it is below 0.1 millisecond.

The greater the choice of current flow periods, the more complete, of course, will be the curve.

Much experimental work has been carried out by Pollock *et alii* in the study of the response of muscle to stimulation by progressive currents, and there has recently been evident in England and elsewhere a tendency to incorporate in these machines triangular wave-forms. This is too lengthy a problem to enter into at this stage; but I think it is fair to state that, while this method does give more information at one end of the curve, on the whole it does not add a great deal.

Finally, the problem is further complicated by variations in the methods of graphing the curves. The method we have used is the simplest one, using logarithmic graphing for time intervals and direct graphing for current strength. In expert hands, various modifications may be preferred, but for general use it is to my mind only unnecessarily confusing to complicate the picture further by introducing such modifications as graphing of the current strength in multiples of rheobase, and logarithmically, instead of directly.

The last question is one which was put to Dr. Bauwens at the recent International Congress of Physical Medicine in London. He was asked: "Which is the better method—electromyography or intensity-time curves?" He replied: "It is like comparing two different drinks." He stated that the two methods overlapped; in certain cases each method could give information that the other could not give. However, it is significant that he concluded by stating that at the present time I-T curves provided a satisfactory method of measuring the excitability of muscle.

While electromyography is a valuable research weapon, for routine electrical testing in nerve lesions there is little to choose between the two methods as regards the value of the information obtained. However, there is a great deal of difference between the two methods from the practical viewpoint. The determination of I-T curves can be carried out fairly rapidly, even in a busy department, while the apparatus is relatively simple and inexpensive. Electromyography requires more expensive and elaborate machines, effective screening against interference and the availability of skilled technicians, and is very time-consuming.

Practical politics have decided the issue, not only here, but in many overseas centres. Ideally, I suppose, we should have both methods.

Acknowledgement.

I wish to acknowledge gratefully the assistance of Miss Muriel Ross, who has been responsible for the preparation of the graphs, and who has assisted in carrying out many of the tests.

Reference.

WEDLICK, L. T. (1953), "Newer Methods of Electrical Testing in Nerve Lesions (I-T Curves)", *M. J. AUSTRALIA*, 1: 261.

The Medical Journal of Australia

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PEACE ON EARTH TO MEN OF GOOD WILL.

"CHRISTMAS comes but once a year" is a trite saying, seen often in literature and heard from time to time on almost everyone's lips. Some say it with gladness and others with dejection, looking on the season as having to be coped with because of the time taken by the arranging and giving of presents and the planning of Christmas dinners—the making of plum puddings and other accompaniments of Christmas feasting. Some no doubt remember the occasion celebrated by the day in the Christian calendar. Christmas Day, by common consent, is a day for children, and large families use it as an occasion for reunion. Family differences and even feuds may be forgotten and discord gives place to harmony. This state of affairs does not take place in a haphazard fashion; it happens because those who take part will it to happen. We know that members of families have many divergent ideas; they have different aims in life and their senses of values differ, in spite, perhaps, of their common upbringing. If they come together and make merry at Christmas time, they do so because they are men and women of good will. The age-long wish or greeting at Christmas time, first uttered nearly two thousand years ago, is "peace on earth to men of good will". What holds for individual families holds also for the nation and for the larger family of mankind in general. At the end of the second World War, we spoke and heard a great deal about the winning of the peace, and we recognized that the task of doing it was as great as, if not greater than,

the task of defeating the enemy. In August, 1945, Amiel was quoted in these pages as describing two kinds of peace. "One rested on the absence of pain and opposition; it was a favour, a luxury, so that it was fragile and dependent. The other was a moral force victorious over all ills, tried, real, positive and able to brave new tempests." The first kind of peace is not, as a rule, of our own devising; we accept it, and if we are honest with ourselves we realize our good fortune. The second kind is entirely different. We have to strive for it with all our energies and to strive without ceasing. The world at present is like an enormous cauldron filled with the desires, aims and efforts of men and nations, and kept simmering by the embers of fear, envy, suspicion and uncharitableness of those who have filled the cauldron. We know that the smouldering embers may be reawakened at any moment by the fanning into flame of any one set of them. Truly this is why peace comes to men of good will, men who will that the embers shall die and the cauldron cease from simmering. This is a matter for every man and woman in every community, and it is appropriate that it should be mentioned at this time because it is only by a wide acceptance of the Christmas spirit that the direful embers will be stamped out. With this we shall all agree. Even in our own community we do well to consider how freedom is curtailed and how assaults are made even on our freedom of thought. Ideas are dinned into us from so many sources that it would sometimes appear that the thought of the community is elaborated for it. We need not go into a discussion on the "four freedoms" and what they imply—that has been done often enough. What we do need to remember is that when we claim and enjoy our own freedom we may be curtailing the freedom of other people. In such circumstances, our duty is to make such adjustments, if possible, after consultation with the other fellow, that each will be content with what remains to him. This again is the Christmas spirit—the spirit of giving.

We may ask what is the Christmas message for the medical practitioner—whether there should be something special for him. He, of course, is just like any other citizen in his responsibilities to the commonwealth, but he has an additional burden by the very nature of his calling. There come to mind two lines which were published a few months ago in *The Canadian Medical Association Journal*:

*L'amour de la médecine fait le savant
L'amour du malade fait le médecin.*

We may, indeed, become men of learning and distinguished scientists if we are devoted to medicine, but without love of the patient as a suffering fellow mortal, we shall never be doctors. Our care of the patient, in terms of this Christmas message, will put his welfare in the foreground. We must regard him in the same way that the citizen, already mentioned, must regard his own freedom. If something which we think is of importance to our own conduct of medical practice conflicts with the comfort or general well-being of the patient, we must be prepared to effect a compromise, and if possible, to meet the wishes of the patient. As we all know, this does not mean that we shall have to make sweeping changes. The patient, or in other words the community, does not always know what is in his best interests, especially when it comes to the prevention of disease, and this has to be taught. It is

in details of method that compromise may have to be effected. If we are devoted to the welfare of the patient, "l'amour du malade", and to no lesser objective, we shall be carrying the Christmas spirit into our daily lives, and that is, or should be, our purpose. Incidentally, by doing our own work to the best of our ability, we shall be acting as men of good will and we shall also be doing something towards the attainment of general peace and happiness.

Current Comment.

THE INHALATION OF GRAIN DUST.

In his recent review of the dust diseases, A. I. C. McLaughlin¹ confines his attention chiefly to dust as an industrial hazard, although he lists grain dusts and seeds as causes of asthma, and flax as a cause of chronic bronchitis and emphysema. The inhalation of grain dust constitutes a significant hazard to those exposed to it, and a review of some of the clinical features may lead to the recognition and study of further cases in this country. One risk is that of infection by one or other of the "ubiquitous fungi", most commonly by *aspergillus*. The onset of aspergillosis is usually insidious rather than acute, and from its chronic course, often with dyspnoea, pyrexia and haemoptysis, is likely to be regarded as tuberculosis or carcinoma. As with other yeast and fungous infections, the diagnosis is often difficult to establish, because the organism is found incidentally or as a contaminant in the sputum of healthy people and particularly those working in dusty atmospheres. In effect, as R. W. Riddell² points out, the diagnosis is usually assumed on the unsatisfactory grounds that the fungus is present in sputum from which tubercle bacilli cannot be isolated in a patient with a chronic pulmonary infection which responds to iodides.

Of possibly greater interest is the condition known as farmer's or thresher's lung, which has recently been reviewed by C. T. Fuller.³ The condition is found in farm workers dealing with mouldy hay; since exposure is usually seasonal, the disease receives little attention as an occupational hazard in comparison with industrial diseases in which exposure is continuous. The aetiology is uncertain; it is unlikely to be a true bronchomycosis, although *Candida albicans* is frequently found in the sputum, though not in the lung lesions. Some form of hypersensitivity phenomenon related perhaps to breakdown of mould spores, grass particles and bronchial epithelium is possible, although sensitivity tests to several moulds gave inconclusive results in several of Fuller's cases. The acute attack occurs on the evening of the day of exposure and is characterized by the sudden onset of pyrexia and cough, with mucopurulent and often blood-stained sputum. Headache and malaise may persist after the respiratory symptoms have subsided in two or three days. Some rhonchi and crepitations are the only abnormal signs. In less acute cases the onset is gradual over perhaps some weeks, with increasing shortness of breath, dry cough, and evening temperature. Cyanosis and basal crepitations are found to be present on examination, and X-ray examination shows a fine alveolar mottling, chiefly in the middle and lower zones. Riddell describes a third phase indistinguishable from pulmonary fibrosis, emphysema and bronchitis of other associations. At all stages the condition is distinguished from asthma by the absence of forced expiration and wheeze, and the lack of eosinophile cells, Curschmann's spirals and Charcot-Leyden crystals in the sputum, which is scanty and mucopurulent rather than copious and tenacious.

¹Lancet, July 18, 1953.

²In "Diseases of the Chest", edited by Sir Geoffrey Marshall and K. Perry, London, Butterworth and Company, 1952.

³Thorax, March, 1953.

V. L. Cohen and Howard Osgood⁴ have presented a series of 11 cases of respiratory disease, characterized at autopsy in three cases by emphysema and interstitial fibrosis, occurring in workers from grain elevators and feed mills. These men showed no evidence of acute tuberculosis, silicosis or fungous infection, and themselves attributed their symptoms to their occupation. They had been exposed to crude grain dust for an average period of twenty-seven years altogether, and for an average of twenty years prior to the onset of symptoms. Thereafter they slowly developed progressive dyspnoea with wheezing, although this was usually preceded by a period of chronic cough beginning in the fifth decade. For reasons given in full in their paper, the authors regard five, possibly seven, cases as atopic—that is, specifically sensitive to crude grain dust or some of its components—but in the remaining cases no such sensitivity was demonstrable. Nevertheless, they consider the inhalation of grain dust responsible for the pulmonary symptoms in both types of case. It would be valuable to know the incidence of this "grain-handler's disease" in the population at risk, since it would appear difficult to distinguish it from emphysema and chronic bronchitis as commonly encountered, apart from the vexed question of sensitivity tests. In this regard it may be mentioned that Cohen and Osgood, in excluding cases of flour-miller's asthma—a recognized clinical entity—note that the patients affected were about a decade younger and were exposed for almost a decade less than the grain workers.

Whatever questions these interesting papers have left unanswered, they lend point to the observation quoted by McLaughlin: "Osler believed that clinical medicine is best learned in the wards of the hospitals, but Rammazzini taught that occupational diseases are most effectively studied in the actual environment of the workers." Country practitioners in particular may well be able to add to our knowledge in this field.

"REACTIONS" TO DEXTRAN.

Of various plasma substitutes introduced in recent years, dextran, usually described as a plasma volume expander, is perhaps the best known and most widely used. One feature of dextran which has pleased most of those who have used it has been the absence of reactions on the part of the patient. As A. W. Wilkinson and I. D. E. Storey¹ have pointed out, this low incidence of reactions has been regarded as one of the most important advantages of dextran as a substitute for plasma. However, more recently, several workers have reported the observation of reactions amongst a high proportion of normal persons who were given infusions of dextran solution. Apparently no satisfactory explanation has been forthcoming of the rarity of all types of reactions when dextran is infused into patients whose blood volume has been reduced by the loss of blood or plasma, and of their relative frequency when the recipient's blood volume is normal. Wilkinson and Storey state that in 1952 a highly fractionated preparation of dextran became available, in which 65% of the material was of molecular weight between 130,000 and 250,000, and more than 40 litres of this preparation have been infused into shocked patients with only two mild and transient reactions. However, it was decided to repeat the experiments reported by some other workers by infusing some of this solution into normal volunteers to see if it produced a high rate of reaction when the blood volume was within normal limits. The five volunteers were healthy, fully grown men, aged twenty-one to thirty-eight years. A 6% solution of dextran in 0.9% saline solution was infused into each of these volunteers, four of them receiving one litre and one receiving half a litre. The rapid initial increase in plasma volume, dilution of plasma proteins and decrease in packed cell volume produced by these infusions were followed by the rapid movement out of

¹J. Allergy, May, 1953.

²Lancet, November 7, 1953.

the vessels of up to 30% of the total circulating plasma protein and infused dextran. Within twelve hours this transfer was reversed, and the plasma volume and the total quantities of plasma protein and dextran in circulation were increased. "Reactions" were produced in each of the five volunteers. There appeared to be two distinct phases in these "reactions". The first was characterized by urticaria; it began during or soon after the infusion was completed and lasted for various periods up to two hours or more after the infusion ceased. The second phase was characterized by vasomotor instability; it usually began after the infusion had been completed and appeared to be related in time to the rapid increase in packed cell volume and the underlying reduction in plasma volume; as the packed cell volume decreased and the plasma volume increased, the tendency to acute vasomotor disturbance declined. Wilkinson and Storey state that other investigators have explained the reduction in albumin and total protein levels during the week after dextran infusion as being due to osmotic suppression of albumin by the circulating dextran. However, it appears likely that at this time there may be more rather than less albumin in circulation. Calculations carried out from the information obtained in this investigation indicated a prolonged increase in plasma volume in the volunteers, and Wilkinson and Storey state that this is in accord with the clinical effects experienced by the volunteers. These effects were greatly reduced exercise tolerance, precordial pain, fullness of the head and breathlessness on exertion. The slow fall in plasma dextran level and the small urinary excretion of dextran observed also fit into the picture.

INFECTION IN BRONCHITIS AND ASTHMA.

It may be surprising to many physicians in this country—free of London fogs and Scottish mists—that C. H. Stuart-Harris and his associates¹ in the University of Sheffield should regard the infective factor in the aetiology and course of chronic bronchitis as a "much neglected one". In view of the ability of the antibiotics to influence this factor, the Sheffield workers endeavoured to assess its role by bacteriological examination of sputum or bronchoscopic washings from patients with chronic bronchitis. We have already referred to their findings in some detail.² *Pneumococci* of all types were found very frequently in all groups, the distribution resembling that observed normally in the naso-pharynx rather than that found in cases of pneumonia. Influenza virus infection was demonstrable from many patients suffering exacerbation, but sometimes from other patients showing no increase in symptoms. This point is of significance, since it is known that even the virus of the common cold, probably by producing cellular damage, facilitates the spread of the usual naso-pharyngeal flora into the normally sterile trachea and bronchi. In fact, at least partly for this reason, the bronchial tree is much less commonly sterile in winter than in summer. It is not surprising therefore that there is a strong seasonal influence in hospital admissions for bronchitis. On the whole, the bacteria identified were similar to those found in a series of cases of bronchiectasis; in conjunction with the findings in regard to the pneumococcus noted above, this was interpreted by the authors as indicating autogenous rather than exogenous infection. Treatment with penicillin, to which the pneumococcus is sensitive, decreased cough and sputum and indicated that the infection was clearly of clinical significance. This clinical "test", which is the only one available for assessing the significance of the bacteriological findings, must also be applied to decide the importance of another commonly identified organism, *Haemophilus influenzae*. The authors stated that terramycin, which is usually inhibitory to the *haemophilus*, can produce further benefit to the patient even after a course of penicillin. J. Robert May,³ who has

published an important paper on the isolation of bacteria from sputum, emphasizes a practical point for the clinician—that there is a significant association between pus in the sputum and the presence of potential pathogens. After a detailed study of the clinical picture in 1000 cases, N. C. Oswald, J. T. Harold and W. J. Martin⁴ have also stressed the importance of episodic infection and climatic changes in modifying the course of chronic bronchitis. The role of infection in bronchitis having been thus established, it is of value to examine two recent contributions dealing with its relationship to asthma. Referring to children, Franklin A. Stevens⁵ describes two clinical "syndromes". The first is exemplified by the experience of those children who develop asthma following colds in the winter but not in the summer. Between attacks, winter or summer, the children are perfectly well, and their chests are normal on examination. Bacteria widely distributed in the community during the winter can be grown from the patients' naso-pharynx during attacks, but are not present in these subjects in summer, nor are they prevalent generally then. According to Stevens, these children show manifestations of skin sensitivity to bacterial nucleoproteins which increase in number and severity during winter and diminish or disappear in the summer months. In these cases the condition is regarded as asthma due to bacterial sensitization. On the other hand there is a group of patients showing single or multiple sensitivity to common inhalants or pollens in whom colds, acting in a non-specific fashion, precipitate asthmatic attacks. In other words, the cold is placed in the same category as emotion, exercise, mechanical irritation by dust, fog and other influences which are known to produce attacks of asthma in susceptible subjects. Stevens finds evidence of "latent asthma" between attacks in this group—for example, "sibilant rales" on auscultation. Stevens's study is based on clinical observation and generalizations from his experience, although it would seem that more detailed data will be available for analysis in a forthcoming paper. The dual action of bacteria in asthma is by no means a new concept, but it requires further investigation by clinicians and bacteriologists.

An entirely different approach to the problem of infection and asthma is adopted by D. A. Williams⁶ in a review of asthmatic deaths in England and Wales, which should do much to dispel the idea that asthma is disabling but rarely lethal. Notable points to which he draws attention are that the death rate from asthma is about seven per 100,000 in an estimated 904 asthmatic subjects per 100,000, that the majority of those dying are over thirty years of age, and that in almost half of the reported cases, but a fifth of his series, the patients have had asthma for less than five years (and many for less than two years). Many therefore fall into the infective or intrinsic asthma group; but in Williams's experience, it is the asthmatic who is subject to recurrent severe *status asthmaticus*, irrespective of the age of onset, who is more likely to die. Williams shows a correlation over ten years between deaths from asthma and from bronchitis, which, although it may be open to some criticism, is striking. In association with the much higher death rate found in the winter months (Registrar-General's figures), Williams suggests that this indicates the importance of "colds" and bronchial infection in the precipitation of severe *status asthmaticus*. In parenthesis, H. O. Lancaster's⁷ statement may be noted, that about 2% of deaths in Australia are due to asthma, but his review of mortality from respiratory disease does not relate asthmatic deaths to those from non-specific respiratory infections. Williams's conclusion brings us back to the value of thorough studies such as that of Stuart-Harris and his colleagues, who have gone some way towards providing a rational approach to the problems of bacterial infection of the bronchi in general and to the problem of chemotherapy in particular. Nevertheless, it is clear that we have a great deal to learn.

¹ *Quart. J. Med.*, April, 1953.

² *M. J. AUSTRALIA*, December 5, 1953.

³ *Lancet*, September 12, 1953.

⁴ *Lancet*, September 26, 1953.

⁵ *J. Allergy*, May, 1953.

⁶ *Thorax*, June, 1953.

⁷ *M. J. AUSTRALIA*, October 31, 1953.

Abstracts from Medical Literature.

GYNAECOLOGY AND OBSTETRICS.

Pregnancies After Caesarean Section.

D. H. EAMES (*Am. J. Obst. & Gynec.*, May, 1953) reviews all articles published in the *American Journal of Obstetrics and Gynecology* which concerned ruptured uterus, Caesarean section, and labour following previous Caesarean section for the past two and a half years. He states that 21,151 sections were performed through the years 1931 to 1951 with 396 maternal deaths—a mortality rate of 1.9%. A foetal mortality rate of 8.5% was estimated. For the period 1940 to 1951, the maternal mortality rate was 0.21% (13 deaths in 6314 sections) and the foetal mortality rate was 5.6% (288 deaths in 5123 sections). Corrected figures, with exclusion of cases in which the cause of death was present prior to surgery, gives a maternal mortality rate (1940-1951) of 0.08% and a foetal mortality rate of 0.5%. The uterus ruptured spontaneously in 19 of the total of 79 cases of ruptured uterus prior to the thirty-seventh week of pregnancy; that is, before the advocates of repeat section would have undertaken any therapy. The incidence of rupture of the uterus in trial vaginal delivery was 2.6% for classical scars (23 in 902 cases) and 1.3% in lower segment scars (11 in 880 cases). The maternal death rate from ruptured Caesarean scars was one death in 44 cases for the classical incision and nil in 21 cases for the lower segment incision. The foetal mortality rate was 18 deaths in 25 cases in the ruptured classical scar group and one death in 14 cases in the lower segment group. The author states that if trial vaginal delivery is used in cases in which a classical scar is present, the following incidence of mortality is to be expected: maternal—0.05%, which is roughly one-half that following routine section; foetal—1.4%, which is a little less than three times that of routine section. In the lower segment group the expected maternal mortality is 0.01%, or one-eighth of the mortality which should occur with routine section, and the foetal mortality 0.07%, which is one-seventh of the mortality expected with routine section.

Constriction Ring Dystocia.

CHARLES FIELDS (*Am. J. Obst. & Gynec.*, May, 1953) analyses 44 cases of constriction ring dystocia. The maternal mortality was nil and the foetal mortality five deaths in the 44 cases. Treatment was by Caesarean section in 33 cases. The author states that the ring is an annular constriction which may occur at various levels of the uterus—most commonly at the junction of the upper and lower uterine segments and frequently over a depression in the foetal outline, for example, around the neck. It occurs in any stage of labour. The frequency is about one in 400 labours. When labour fails to progress, despite an apparently normal presentation and position and the absence of disproportion, constriction ring should be suspected. In the first stage a depression or groove may be felt or seen

abdominally, the cervix hangs loosely like a cuff, especially during a uterine contraction, and the head is easily rocked in the pelvis. In the second stage the presenting part often recedes during a contraction, and the lower uterine segment and cervix are flaccid. The absolute diagnosis is made by an intrauterine examination, when the ring can be felt. The management depends on early recognition of the cause of the delayed labour and effective treatment of prolonged labour, if it occurs, by general supportive measures. Relaxation of the ring before delivery will avoid a traumatic delivery; to this end papaverine or "Spasmalgin" in the first stage and amyl nitrate in the second stage may be of value. If these fail, treatment should be by Caesarean section; a longitudinal incision in the lower segment is recommended in order that the incision can be extended, if necessary, to include the constriction ring. With the increased use of intravenous pituitrin therapy in prolonged labour unsuspected constriction rings may become more pronounced. In this series pituitrin was used in only three cases; there was a suspected ring in one case, and this was intensified.

Cation-Anion Exchange Resin in the Control of Oedema.

J. P. BAKER, J. J. LEHMAN, H. A. CLAIBORNE AND W. S. BAKER (*Am. J. Obst. & Gynec.*, May, 1953) present their results in the treatment of oedema in pre-natal patients with a cation-anion exchange resin. They state that the resins interfere with the absorption of cations (sodium, potassium, magnesium, calcium) and anions from the gastro-intestinal tract by entering into an insoluble combination, which is removed from the body via the faeces. The process is a non-selective one, and the removal of other cations than sodium, particularly potassium, may result in an undesired negative balance of these other cations, in association with the desired negative sodium balance. When the resins are utilized for therapy, dietetic restriction of sodium may be relaxed; the results of treatment are better when the dietary sodium is increased. As the efficiency of the resins is in direct proportion to the rate at which they move through the gastro-intestinal tract, satisfactory bowel function must be maintained. With establishment of evacuation, decrease in oedema and loss of weight becomes much more pronounced. The general effect of the resins on the blood pressure is to lower it significantly. Prolonged administration of the exchange resins requires a diet adequate in potassium content, with serial electrocardiography and repeated blood chemistry determinations. For short-term dosage (not exceeding five days in the authors' series) it may be given safely.

Ectopic Pregnancy.

BENJAMIN LEFF (*Am. J. Obst. & Gynec.*, June, 1953) presents a study of 266 consecutive cases of ectopic pregnancy, in which operation was performed with no mortality. He states that in 1876 the mortality rate was 73%, and in 1949 the figure was 1.7% for the United States; he attempts to evaluate the downward trend. He states that correct diagnosis is essential for early treatment; this was made in 90%

of his cases. The early treatment of shock and particularly the use of blood transfusion is regarded as the greatest single factor in reducing the mortality rate. Reported fatalities, by and large, are considered to be due to irreversible shock.

Total Hysterectomy at Caesarean Section and in the Puerperium.

I. DYER, F. G. NIX, J. C. WEED AND C. H. TYRONE (*Am. J. Obst. & Gynec.*, March, 1953) report a study of 85 patients who were treated by total hysterectomy at Caesarean section or in the immediate puerperium. Of the total hysterectomies 75 were performed at the Tulane Obstetrical Services over a period of three and a half years. The Caesarean section incidence at the Tulane Obstetrical Services was 150 sections per year and represented 3.7% of the total deliveries. Of the Caesarean sections 45% were repeat procedures, 23% being for disproportion; the great majority were for indications such as toxæmia of pregnancy, *abruptio placentæ*, *placenta prævia* and uterine fibroids. The authors consider that hysterectomy has to be considered in many of these cases. Moreover, obstetrical emergencies, such as neglected compound presentations with intrapartum sepsis, ruptured uteri and long-standing massive placental separation, often require immediate hysterectomy as a life-saving measure for the mother. Among the 85 total hysterectomies there were 77 deliberate total Caesarean hysterectomies and eight total hysterectomies in the immediate post-partum period. The eight emergency operations were as follows: five for rupture of the uterus, two for *placenta accreta*, one for Couvelaire uterus. The authors consider that the indications for total hysterectomy at Caesarean section or in the immediate puerperium are the same as for the subtotal or Porro operation. The technique of their operation is described; it includes delivery of the infant through a low transverse incision in the uterus, continuation of the transverse incision in the uterus to effect complete amputation of the uterus, division of the vagina and excision of the remaining lower uterine segment and cervix, suture of the vaginal vault and approximation of the supports of the pelvic floor. There were two maternal deaths in the series, one due to peritonitis associated with a ruptured uterus, and the other occurred in a patient with eclampsia, *abruptio placentæ* and a Couvelaire uterus. The authors conclude that a total abdominal hysterectomy can and should be performed whenever hysterectomy is indicated, either at the time of Caesarean section or in the puerperium.

Intraepithelial Carcinoma of the Vulva.

S. H. GARDINER, F. E. STOUT, J. L. ARBOGAST AND CARL P. HUBER (*Am. J. Obst. & Gynec.*, March, 1953) report 112 cases of carcinoma of the vulva with detailed observations on eight patients who had intraepithelial carcinoma of the vulva. The authors consider that carcinoma of the vulva probably exists in the intraepithelial phase more frequently than is generally reported, and that the early recognition of this pre-invasive lesion, followed by adequate surgical removal,

would result in an increased survival rate. The outstanding symptoms in the eight cases of intraepithelial carcinoma were vulval itching and the presence of a small vulval swelling. The authors state that intraepithelial vulval carcinoma usually appears as a reddened, velvety, flat or slightly elevated, delineated lesion. The invasive phase of the neoplasm manifests itself by the appearance of nodulation or ulceration in the centre of the lesion. When examined microscopically, the epithelium is said to be, usually, of normal thickness with loss of the normal stratification of the epithelial cells. An absence of the usual progressive maturation from the basal cells outwards is described. The cells are undifferentiated, the nuclei are variable, and mitotic figures are frequent. The authors describe two cases in which the intraepithelial phase persisted for seven and eleven years respectively before invasion occurred. In two other cases there were large intraepithelial lesions with early central invasive carcinoma. In the four remaining cases there was gross invasive carcinoma with microscopic evidence of intraepithelial carcinoma at the periphery of the invasive neoplasm. A histological study of the area of skin adjacent to invasive vulvar carcinoma in 112 cases showed normal epithelium in 44% of cases, leucoplakia in 23%, no bordering epithelium in 22%, intraepithelial carcinoma in 7% and kraurosis in 4%. The authors stress the importance of recognizing that inflammatory acanthosis can produce a microscopic picture which closely resembles both leucoplakia and intraepithelial carcinoma. Further histological studies suggested that lower grades of malignant change in vulval carcinoma are found most consistently in neoplasms which develop in leucoplakia or normal epithelium. Invasive carcinoma arising in an intraepithelial lesion showed a high grade of malignancy in those cases in which the pre-invasive phase was short. The authors discuss the differential diagnosis of intraepithelial carcinoma of the vulva from disease such as Paget's disease, Bowen's disease, arsenical dermatitis, radiation dermatitis, inflammatory acanthosis and leucoplakia. They consider that the presence of intraepithelial carcinoma is an indication for complete vulvectomy. If the invasive phase is present, radical vulvectomy and lymph node dissection should be performed.

Fœtal Welfare and Placenta Prævia.

R. P. NEILSON AND D. R. NEILSON (*West J. Surg.*, April, 1953) review 220 patients with placenta prævia treated at the Emanuel Maternity Hospital and discuss various measures directed towards improving the fetal salvage in this condition. They state that reported results of treatment of placenta prævia over the past fifteen years show a reduction of maternal mortality from 7% to less than 1% in recent years; but fetal welfare, though improved, is not comparable with the maternal figure. There were no maternal deaths in the series reported, and the fetal mortality rate was 13.4%. The authors discuss the expectant treatment of placenta prævia, the method which they employed in 76 cases in the series. They consider this to be the outstanding single factor which has caused a reduction in fetal

loss associated with placenta prævia. Prematurity continues to be the most important cause of fetal death associated with placenta prævia; expectant management, while not compromising the safety of the mother, has prolonged the period of gestation to the relatively safe period of thirty-six weeks and longer. The authors discuss improved pædiatric care in fetal salvage, and their figures suggest that fetal mortality among liveborn premature babies in this series has fallen from 50% in 1942 to 20% at present. The authors consider that it is usually possible and advisable to diagnose placenta prævia without the added hazard of intracervical palpation of the placenta. Alarming hæmorrhage occurred in eight patients of the series who were thus examined vaginally. Moreover, the results of intracervical palpation are not always conclusive. Improved prenatal supervision is stressed, and particular attention is paid to the mother's general condition as well as to the earlier diagnosis of placenta prævia as practised by Stallworthy. The avoidance of traumatic delivery is considered important in fetal salvage, and the authors make no apology for a Cæsarean section rate of 78%. Traumatic procedures such as "bagging" and version are avoided except in grave emergencies. Better anaesthesia, the use of local anaesthesia until the baby is delivered and prompt recognition and treatment of post-hæmorrhagic shock in the newborn are other factors stressed in attempting to improve fetal salvage in placenta prævia.

"Trilene."

CHARLES E. FLOWERS (*Am. J. Obst. & Gynec.*, May, 1953) summarizes his experiences with "Trilene" as an adjunct to obstetrical anaesthesia and analgesia. He states that it is a potent analgesic drug, whose margin of safety and ease of administration will ultimately make it a standard agent on all delivery floors. Its wide variety of uses will probably allow almost every obstetrician to find a place for it in his obstetrical practice.

Percutaneous Retrograde Iliac Arteriography and Tubal Pregnancy.

U. BORELL, I. FERNSTROM AND A. WESTMAN (*West. J. Surg.*, May, 1953) report observations on the diagnostic value of percutaneous retrograde arteriography of the iliac artery in cases of tubal pregnancy. Six cases are reported, in four of which the presence of a tubal pregnancy was diagnosed by arteriography. The authors observe that most cases of extrauterine pregnancy do not present difficulty in diagnosis. In other cases with tubal abortion and intermittent slight pain diagnosis may be difficult. A biological test of pregnancy may be helpful, and a survey by X-ray films of the abdomen may be of assistance if it reveals free fluid in the peritoneal cavity. Hystero-salpingography and pneumoperitoneum with X-ray examination are uncertain in diagnosis and may be contraindicated. Diagnosis by arteriography depends on the fact that blood vessels surrounding the placental villi in a tubal pregnancy are widened, and many new blood vessels are formed.

In studying the arteriograms the width of the tubal branch of the uterine artery is noted and evidence of placental sinuses in a tube is demonstrated by a density due to opaque medium, which may be of variable size and shape, often showing small irregular defects. The authors noted that in two cases of proven tubal pregnancy negative results were obtained from arteriograms. In one case the finding was considered to be due to a pregnancy of short duration in which the placental sinuses either had not yet developed or were not large enough to show in an arteriogram. In the other case the ectopic pregnancy had ruptured; all the placental tissue had escaped into the peritoneal cavity, and placental sinuses were no longer present in the tubal mass. Arteriography performed by the authors on 20 patients with normal uterine pregnancies had no untoward effects on the patients or the pregnancies. The authors consider this a safe procedure in the investigation of suspected extrauterine pregnancy complicating a normal uterine pregnancy.

Dysmenorrhœa.

N. F. MILLER AND S. J. BEHRMAN (*Am. J. Obst. & Gynec.*, March, 1953) discuss the problems of primary dysmenorrhœa and make suggestions for its control. They define dysmenorrhœa as a syndrome, characterized by such subjective symptoms as uterine cramps, pelvic discomfort, nausea, vomiting, malaise, premenstrual tension and other variable disturbances, occurring in association with menstruation. The chief clinical characteristics of primary dysmenorrhœa are summarized as follows: the condition generally commences within a year or two after the menarche; the pain is commonly crampy in character and is frequently associated with nausea, vomiting, or premenstrual tension; primary dysmenorrhœa seldom, if ever, occurs in the absence of ovulation; the absence of palpable pelvic pathological lesions is essential before a diagnosis is made of primary dysmenorrhœa. The condition tends to disappear with maturity and after the birth of a full-term fetus. The authors do not think that all the symptoms of primary dysmenorrhœa can be explained on the basis of any single causative factor. They think it probable that there exists a dysfunctional synergy between hormonal chemical regulators, myometrium and other receptors such as the uterine vascular tree. Two basic factors are thought to be present—myometrial hypercontractility and angiospasm. The treatment of primary dysmenorrhœa is discussed on the basis of the following broad principles: the acceptance of temporary disability and resort to bed rest and heat; the exhibition of pain-relieving drugs; the prevention or interruption of ovulation; surgery, which may be necessary in intractable cases. Small doses of codeine are recommended when the simpler analgesics are ineffective. The authors consider that treatment by inhibiting ovulation (by adequate doses of oestrogen or testosterone) should be utilized for restricted periods of time only. The indications for surgery in primary dysmenorrhœa can be established only after time has permitted a thorough attempt at relief by other methods without success.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at Newland House, Brougham Place, North Adelaide, on October 26, 27, 28 and 29, 1953, Dr. A. J. COLLINS, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. A. J. Collins, D.S.O., M.C., Dr. W. Simmons, Dr. H. R. R. Grieve, Dr. A. J. Murray, O.B.E.

Queensland: Dr. A. E. Lee, Dr. H. W. Horn.

South Australia: Dr. L. R. Mallen, Dr. C. O. F. Rieger.

Tasmania: Dr. J. B. G. Muir, Dr. T. Giblin.

Victoria: Dr. H. C. Colville, Dr. Charles Byrne, Dr. Robert Southby.

Western Australia: Dr. H. Leigh Cook, Dr. D. E. Copping.

Minutes.

The minutes of the meeting of the Federal Council of February 23, 24 and 25, 1953, which had been circulated amongst members, were taken as read and approved.

Finance.

The financial statement of the Federal Council as at October 21, 1953, was presented by Dr. W. F. Simmons, the treasurer, and adopted. Dr. Simmons also presented a statement setting out the payments to the Federal Council by the several Branches up to the date of the meeting. The Federal Council then discussed the capitation rate for 1954 and resolved that the contribution of the Branches to the expenses of the Federal Council for the year 1954 should be at the rate of 21s. for each member on the membership list as at January 1, 1954.

The Federal Council then dealt with a notice of motion which had been given by Dr. W. F. Simmons. It had to do with the expenses of members of the Federal Council attending meetings. It was resolved that By-Law 15 (i) should be amended by the deletion of the words "63s." wherever they occurred, and by the substitution in lieu thereof of the words "84s." so that the by-law would read as follows:

The expenses of members of the Federal Council attending any meeting of the Federal Council or of a committee or subcommittee thereof, which, in pursuance of the regulations, are to be defrayed out of the general funds of the Council, are the first class travelling expenses; and in the case of a member attending a meeting who is unable to return home from the meeting at night from the place of meeting, the sum of eighty-four shillings shall be paid to him for every night necessarily absent from home and the sum of eighty-four shillings for each day necessarily absent from his practice.

It was resolved that the amendment should have effect as from February 1, 1953.

Dr. Simmons also made a statement in regard to the organization fund of the Federal Council for the period January 1, 1953, to October 21, 1953. The amount standing to the credit of the organization fund at the latter date was £1881 6s. 8d.

Dr. Simmons referred to the Federal Independence Fund which had been discussed at two previous meetings of the Federal Council. He reminded members of the Council that when the fund was established the promise was made to contributors that the residue of the fund would be returned to them on a *pro rata* basis when the money was no longer needed. At the previous meeting of the Federal Council it had been resolved that the contributors to the fund should be communicated with individually to the effect that the Federal Council was ready to return to them *pro rata* to their contributions the balance in credit. Further, the Federal Council decided that individual contributors should be informed that the Federal Council considered that the need for the fund continued, and that each contributor should be invited, therefore, to leave the balance to which he was entitled at the disposal of the fund. Dr. Simmons reported that the balance of the fund at December 31, 1952, had been £26,304 7s. 5d., and that the return of unexpended portion of contributions had been made in respect of deceased

members to the extent of £744 15s. 8d., and in respect of members who had requested their contributions to be returned, to the extent of £3142 7s. 1d. The balance of the fund at October 21, 1953, was £22,695 0s. 3d. In Dr. Simmons's statement, it was pointed out that included in the refunds requested were two from the New South Wales Branch and three from the Western Australian Branch, in which it was directed that the portion amounting to £22 17s. 6d. should be donated to the Federal Medical War Relief Fund, and there was also one from the Victorian Branch amounting to £5 5s. which was to be given to the Victorian Medical Benevolent Association. Also included in the refunds requested by the Victorian Branch was one amount of £500 paid to the Medical Society of Victoria Organization Fund.

Dr. Simmons pointed out that the Entertainment Fund stood at £245 15s. 7d.

Medical Officers' Relief Fund (Federal).

Dr. Simmons, on behalf of the trustees, presented an interim report of the Medical Officers' Relief Fund (Federal). The report covered the period of six months ended June 30, 1953. At June 30, 1953, the total assets of the fund, exclusive of interest owing on loans, amounted to £8059 12s. 8d. Since December 31, 1952, one of the three loans in existence had been paid in full. One loan, totalling £700, was outstanding, and interest only was being paid. Another loan was for £505 and the debtor had died. The report was adopted.

Federal Medical War Relief Fund.

Dr. Simmons, on behalf of the trustees, presented the interim report of the Federal Medical War Relief Fund for the six months ended June 30, 1953. He pointed out that the total amount of the fund at June 30, 1953, was £19,746 19s. 6d. At the present time, assistance was being given in the education of several children. Some of these were young and the amount which would be expended would increase as time advanced. The report was adopted.

The Henry Simpson Newland Prize Fund in Surgery.

Dr. Simmons presented a financial statement in regard to the Henry Simpson Newland Prize Fund in Surgery. It was pointed out that the choice of a subject for the essay was in the hands of a subcommittee.

The subcommittee appointed to choose a subject for the Henry Simpson Newland Prize Essay—Dr. H. C. Colville, Dr. A. E. Lee, Dr. C. O. F. Rieger and Dr. J. B. G. Muir—reported at a later stage of the meeting that they had chosen as a subject for the first essay "The Influence Upon Surgical Practice of Irradiation and Endocrine Therapy".

The Coronation of Her Majesty Queen Elizabeth II.

The General Secretary reported that in consequence of a request by the Prime Minister for a representative of the medical profession to attend the Coronation of Her Majesty Queen Elizabeth II at Westminster Abbey on June 2, 1953, Sir Edmund and Lady Britten Jones had been nominated. They had attended the Coronation ceremonies.

The General Secretary also explained that a message of loyalty to Her Majesty from the President of the Federal Council on behalf of the medical profession in Australia had been forwarded to the Press on May 29, 1953, for publication on June 2, 1953.

Honours.

The General Secretary reported that congratulations had been offered to the following medical practitioners who had received honours from Her Majesty the Queen: Dr. Gilbert Brown, C.B.E., Colonel K. B. Fraser, C.B.E., and Dr. F. J. Graham, M.B.E.

Medical Practice in Australia: Inquiries from Practitioners Overseas.

The General Secretary reported that he had received from several practitioners overseas inquiries about the possibilities of medical practice in Australia. He had tried to supply the information required. He had also received inquiries from Swiss Medical Institutions and he had explained the conditions of registration in the several States.

The Medical Association of Israel.

Reference was made to previous mention at a Federal Council of accusation against physicians in the U.S.S.R. It was noted that the doctors concerned had been released and exonerated of all charges.

The Board of Medical Examiners of Puerto Rico.

The General Secretary said that he had received a communication from the Government of Puerto Rico inquiring into the educational standard of the University of Queensland. He had replied, setting out the details of the medical course and of the standard of medical education.

Radiological Services in Great Britain.

The General Secretary said that he had received from Dr. D. G. Maitland a copy of some comments of the Faculty of Radiologists on the increasing costs of radiological services under the National Health Service in Great Britain. The contents of the communication were noted.

The Australian and New Zealand Association for the Advancement of Science.

The General Secretary reported that he had received a request from the Australian and New Zealand Association for the Advancement of Science for the appointment of two representatives of the Federal Council to attend the thirtieth meeting of the Association at Canberra from January 13 to 20, 1954. Dr. E. Beatrix Durie and Dr. E. F. Thomson were appointed.

The Northern Territory Medical Service.

The General Secretary reported that he had received a request from the Victorian Branch, asking for particulars on the cost of the Northern Territory Medical Service. The General Secretary's reply gave details of hospital and health services, ambulance services and so on. These amounted in all to a total of £557,098. He explained that the population of the Northern Territory was between 16 and 17 thousand people.

The American Academy of General Practice.

The General Secretary reported that he had received from the American Academy of General Practice a statement setting out details of its inception, objectives and functioning. This document led to a short discussion on the fact that several discussions had taken place in different States in regard to the possibility of the formation of a college of general practitioners in Australia. It was pointed out that those who had urged that something be done in the matter were sincere and idealistic in their approach to the subject. The General Secretary pointed out that nowhere in the world was the status of general practitioners so high as in Australia; nowhere was their professional freedom greater. The President expressed the view that the Federal Council should try to serve the general practitioners as well as was possible. It was eventually decided that the General Secretary should write to the several Branches and find out from them what views were held and what was being done in the matter in the several States.

King George VI Memorial Fund.

The General Secretary reported that he had received a request from the Lord Mayor of Sydney inviting a representative of the Federal Council to attend a meeting on August 10, 1953, to inaugurate the King George VI Memorial Fund. Dr. T. Y. Nelson, the President-Elect of the New South Wales Branch, had been asked to attend the meeting and he had done so and submitted a report.

Union of German Doctors.

At the previous meeting of the Federal Council, a letter was read from the Union of German Doctors (*Verband der Ärzte Deutschlands*), forwarding a copy of its journal and asking whether it could receive the official journal of the Association in exchange. The Federal Council, on that occasion, resolved that the matter should be left in the hands of Dr. L. R. Mallen, the Federal Council's representative on the Council of the World Medical Association. The General Secretary reported that no further information had been received from the World Medical Association. No further action was taken.

An Alleged Shortage of Doctors in the Auburn Municipality.

The General Secretary reported that he had received a letter from Sir Earle Page, the Minister for Health, forwarding a letter received by him from Mr. E. J. Harrison, M.P. for Blaxland, concerning a complaint received regarding shortage of doctors in the Auburn Municipality, New South Wales. The General Secretary had communicated with the New South Wales Branch and had informed the Minister that there were twelve doctors practising in the area.

International Hydro-Climatological and Thalassotherapeutic Congress.

The General Secretary reported that he had received a letter from the Consul-General of the Republic of Yugoslavia, informing him that the International Hydro-Climatological and Thalassotherapeutic Congress would be held at Dubrovnik, Yugoslavia, on May 8 to 16, 1954. The Congress would be organized by the Association of Medical Societies of Yugoslavia. The information had been sent to the several Branches.

Inquiries from Argentina About the British Medical Association in Australia.

The Secretary-General said that he had received a letter from the Director-General of Information of the Ministry of Health, Argentina, asking for particulars regarding the British Medical Association in Australia. The information had been sent.

Inquiries from Italy About Medical Registration in Australia.

The General Secretary reported that he had received an inquiry from Milan, asking whether there had been any alteration in the laws of the registration of medical practitioners in Australia. He explained that in 1951 some graduates of Milan had wished to practise in Australia and that they had been informed that there was no reciprocity between any of the Australian States and Italy. In the recent letter, they wished to know whether any change had been made since that date. The General Secretary had replied that no changes had taken place.

Medical Benefits to Returned Soldiers.

The General Secretary reported that he had received a letter from the American Medical Association, seeking information in regard to the provision of medical benefits to returned soldiers (veterans). The information was being collected.

The Treatment of British Ex-Servicemen Resident in Australia.

The General Secretary reported that he had received a letter from the Disabled Soldiers Council of Victoria, asking for the cooperation of the Association in supporting a claim for the better treatment for British ex-servicemen resident in Australia. It was explained that the British Ministry of Pensions had disregarded certificates from senior Australian practitioners in regard to conditions said to be attributable to war service. British ex-servicemen resident in Australia were, as a result, at a considerable disadvantage. It was stated that the Repatriation Commission in Australia was much more liberal than the British Ministry of Pensions. Dr. T. Giblin said that two points arose in the matter. The first had to do with the difference in treatment as between that given in Britain and that given in Australia; this was not a matter for the Federal Council. The second point had to do with the action of the British Ministry of Health in disregarding certificates by reputable Australian practitioners. He thought that something might be done to press the claims of the British ex-servicemen in this matter. Dr. H. R. R. Grieve said that something should be done. He thought that an approach might be made to the Parent Body, and said that, of course, British ex-servicemen resident in Australia had to rely on Australian medical practitioners. It was resolved that the General Secretary should inquire into the matter.

Australasian Medical Congress (British Medical Association).

Sixth Session.

The General Secretary reported that an outstanding account of £63 18s. had been paid on account of the hire of a marquee which was lost at the time of the holding of the Sixth Session of the Congress in Perth. The paying of this account had brought the total loss on the Congress to a sum of £262 7s. 3d.

Seventh Session.

Further reference was made to a request by the Section of Ophthalmology of the Seventh Session that a standard form for certification of the blind should be adopted. It was reported that the Social Services Department had adopted a standard form, Form SA47, and had distributed it to all State departments, together with instructions to directors on its use.

Eighth Session.

At the previous meeting of the Federal Council, reference was made to a resolution of the Section of Orthopaedics and Physical Medicine to the effect that the Federal Council should be approached to consider recommendations that the existing law should be altered, where necessary, to provide that legal actions or damages against medical practitioners for allegations of negligence should be decided by a judge and not by a jury. On that occasion the Federal Council decided to defer consideration. The Federal Council had before it a lengthy report by the legal advisers of the New South Wales Branch. Dr. A. E. Lee said that he thought that the problem arose only in New South Wales. After discussion, it was resolved that in view of the fact that the problem could not be dealt with on a Federal basis, the matter should be referred to the Branches, with a request that any action taken should be reported to the Federal Council.

The General Secretary also said that he had received from the President of the Victorian Branch a refund of £1393 18s. 3d., which represented a surplus from the Eighth Session of Congress.

Ninth Session.

At its previous meeting, the Federal Council, on the nomination of the New South Wales Branch, appointed Dr. A. J. Collins, D.S.O., M.C., as President of the Ninth Session of Congress. The General Secretary reported that on May 15, 1953, a meeting of the general committee of the Ninth Session had been held, and the minutes of the meeting were presented. He said that the Congress would be held from Saturday, August 20, to Saturday, August 27, 1955, at the University of Sydney. An Executive Committee had been elected, a Finance Committee had been elected, and also an Editorial Committee. The Honorary Secretary for the Congress was Dr. J. G. Hunter, and the Honorary Treasurer, Dr. George Bell.

The first meeting of the Executive Committee had been held on June 12, 1953, and its minutes were presented.

A request from the Executive Committee for the advance of £500 for preliminary expenses was received and the amount voted.

Australasian Medical Publishing Company, Limited.

The General Secretary reported that he had received a notice of the meeting of directors of the Australasian Medical Publishing Company, Limited, to be held at Adelaide on October 25, 1953. The fortieth ordinary general meeting of the company would be held in Sydney on November 11, 1953.

Pharmaceutical Benefits Act, 1947-1952.

At its previous meeting, the Federal Council had discussed the amendment to Regulation 14A of the *Pharmaceutical Benefits Act*. In this regulation, it was declared that certain pharmaceutical benefits could be prescribed only for the treatment of certain specified diseases. The General Secretary reported that restrictions regarding the use of thyroid had been lifted.

The Federal Council had before it a list of suggestions which had been received for the inclusion of additional benefits under the Act. These suggestions came from the New South Wales Branch, the Victorian Branch, the Australian Paediatric Association, the South Australian Branch, the Australian Society of Allergists and the Queensland Branch. The General Secretary said that all recommendations had been sent on to the Director-General of Health for consideration by the Pharmaceutical Benefits Advisory Committee.

Medical Planning.*Pensioner Medical Service.*

The first item on the agenda paper under the heading of Pensioner Medical Service dealt with blind pensioners. The possible inclusion of these persons in the Pensioner Medical Service was discussed at the previous meeting of the Federal Council. (See *THE MEDICAL JOURNAL OF AUSTRALIA*, April 18, 1953, page 563.) On that occasion, the Federal Council resolved that it would inform the Minister that, in its opinion, the agreement with the Government that the fees under the Pensioner Medical Service would remain unchanged for three years, implied that there would be no alteration in the categories of pensions or conditions of service during that period, and furthermore, that the Federal Council was unwilling that any group of persons

should be added to the list of pensioners eligible for pensioner medical benefits without a means test or as the result of the liberalization of the means test. The General Secretary said that he had written to the Minister, and had received a reply from him in which he expressed his regret that the Federal Council was unwilling that blind pensioners receiving invalid pensions without application of a means test should continue to be included in the Pensioner Medical Service. He stated that there were less than 700 such pensioners, representing a very small proportion of the pensioners enrolled in the Service. The effect upon the 3800 participating medical practitioners would, he thought, be negligible. The General Secretary said that he had forwarded this letter to the Branches and that most of them had agreed to accept the Minister's suggestion. The Victorian Branch, however, maintained its view that the arrangement with the Government implied that there would be no alteration in categories of pensioners or conditions of service. Dr. Charles Byrne said that he objected to wealthy blind pensioners being treated on the Pensioner Medical Service. Dr. H. C. Colville said that the matter would come up again later on during the meeting and that he thought it might well be deferred and considered together with other matters. This the Federal Council decided to do.

At the previous meeting of the Federal Council, consideration was given to the Federal Advisory Committee's recommendation for further modification of the mileage rates. A suggestion had been made that the Commonwealth should accept responsibility for the payment of mileage at the full rate of 5s. per mile one way from 13 miles from the doctor's surgery and within his area. The Minister, in the course of a letter on the Pensioner Medical Service, had stated that the suggestion was not acceptable to the Federal Treasurer or himself. The Federal Council had then directed the General Secretary to write to the Minister again. In his letter, the General Secretary stated that the Federal Council was of the opinion that the decision of the Government on the payment of mileage made an invidious distinction between city and country practitioners. It therefore asked that its submission on the matter should receive further consideration. A reply had been received from the Minister stating that no variation could be made in the present mileage arrangements. It was resolved that no further action should be taken in respect of the request to the Minister for Health that mileage beyond 13 miles be paid by the Commonwealth Government. Consideration was given, however, to circumstances which were described in a communication from the New South Wales Branch. In one instance, a pensioner lived in an area between two towns. In one of these towns several doctors were practising and in the other only one practitioner lived, and he had almost retired from practice and was not always available. The former town was further from the patient than the latter town. The patient had summoned a doctor from the former town and the Commonwealth had refused to pay the mileage. The New South Wales Branch suggested that when a pensioner was attended by a doctor who did not live nearest to him, the mileage should be based on the distance between the patient's residence and the nearest doctor. After discussion in which mention was made of the subdivision of the States into various areas, and views in opposition to this subdivision had been expressed, the Federal Council resolved to recommend to the Minister that in respect of mileage in country areas, in order that the patient might have free choice of doctor, mileage should be estimated on the distance of the patient from the nearest practitioner.

Discussion took place on the certification for Friendly Societies Sickness Benefits in the Pensioner Medical Service. In a letter to the Minister on May 18, 1953, the General Secretary had referred to a statement made in a letter issued to medical practitioners participating in the Pensioner Medical Service in connexion with the scope of the Service as follows: "It will extend to certification (without additional fee) for Friendly Societies Sickness Benefits if required, in the course of medical attention." A reply had been received from the Minister bearing the date June 1, 1953. In his reply, the Minister referred to discussions and correspondence which had taken place between his department and the Federal Council in October, 1950. In these, no mention had been made of the subject under discussion, and no mention had been made of it in a letter dated December 22, 1950. The Minister, therefore, said that he had felt justified in understanding that the Federal Council accepted the revised definition suggested in his letter. The General Secretary said that the correspondence had been forwarded to the Branches and the opinion was expressed that no further action should be taken. This view was accepted by the Federal Council.

Mention was made of rates for attendance. This arose from a letter received by the Western Australian Branch from the Deputy Director of Health of the Commonwealth Department of Health in Western Australia. In this letter, mention was made of attendance by a medical practitioner on a pensioner, 79 daily visits having been paid. The Director-General of Health had written stating that the case was one for reference to the Pensioner Medical Service Federal Committee of Inquiry. At the same time, he understood that most medical practitioners in Western Australia compromised in such cases by submitting two or three weekly vouchers, dependent on the condition under treatment. The Deputy Director-General wished to know the views of the Council of the Western Australian Branch. The Branch Council had sent a reply stating that the Pensioner Medical Service was already on a concessional basis, and that any attempt to establish a weekly rate would make an already considerable concession much greater. This would operate to the detriment of the doctor who had a serious or difficult case which required a great deal of time and effort each day. It was true that most practitioners compromised by submitting two or three vouchers every week, depending on the condition under treatment, and there would appear to be little abuse under the existing order. The Pensioner Medical Service Committees of Inquiry would deal with cases of abuse if they arose. In view of the fact that no cases had been submitted to their inquiry, it was assumed that all cases so far, including the one of 79 consecutive daily visits, had been reasonably explained. Until it had been shown that there was abuse under the present rates, and until the present machinery had been demonstrated to be inadequate for the purpose of dealing with abuses, practitioners in Western Australia would strongly resent fixing of weekly rates. The correspondence was noted.

Reference was made to the Committees of Inquiry which had been discussed at the previous meeting of the Federal Council. On that occasion, several questions in regard to the committees had been raised. The Federal Council had before it copies of a document entitled "Notes for the Guidance of Members of the Pensioner Medical Service Committees of Inquiry". The view was expressed that these instructions were quite adequate. A discussion then took place on a suggestion by the Queensland Branch that when a complaint against a medical practitioner was upheld by a committee, a copy of the résumé of the offence and determination of the Minister should be forwarded to the Branch Councils. It was thought that no name might be mentioned, but only a description of the offence, and the penalty inflicted should be given without the name of the offender. It was pointed out that in one instance in which a practitioner had been made to return a certain sum of money, no mention was made of the matter in the *Commonwealth of Australia Gazette*. It was explained that in the instance referred to, the payment of the money was regarded as a repayment and not as a fine, and thus the name had not appeared in the *Gazette*. Dr. Leigh Cook pointed out that any inquiry by the Committees of Inquiry was analogous to the holding of a Coroner's inquest and the trial of a person found guilty by the Coroner. No action was taken in the matter.

A discussion took place on what constituted over-visiting. Several members of the Council pointed out that this was extremely hard to determine. One member pointed out that if a doctor was consistently paying a large number of visits to many pensioners, he would naturally be suspected of over-visiting. It was also stated that if a practitioner was brought before a Committee of Inquiry, the fact would soon become known among his colleagues and this was a very strong deterrent. Dr. H. R. R. Grieve said that one thing a doctor would feel more than anything else was the opprobrium of his colleagues.

The General Secretary reported that he had received from the Department of Health further lists of practitioners willing to provide service to pensioners. Reference was also made to the lack of participation by doctors in certain towns in the conduct of the Pensioner Medical Service. The suggestion had been made that in these circumstances practitioners might be "induced" to join the Service. Dr. H. C. Colville said that he took a very poor view of the use of the word "induce". This was a concessional service, and it had been stated at the outset that the response on behalf of medical men might not be good. It was explained, however, that in one Victorian town where two doctors were practising, neither of them had agreed to undertake the Pensioner Medical Service. When the facts and the plight of the pensioners had been explained to them, both of them had agreed to do the work. Dr. Colville thought that the Federal

Council should be firm in the view that it had no obligation to induce anyone to join the Service.

The General Secretary read a letter which he had received from the Director-General of Health, in which it was stated that it had come to his notice that at least one of the medical practitioners engaged in the Pensioner Medical Service had no surgery, waiting room or telephone. He had operated, apparently, through certain hostels and had been submitting his claims. The Director-General thought that it was highly desirable that any medical practitioner engaging in the Pensioner Medical Service should have the basic requirements of a medical practitioner—a surgery, a waiting room and a telephone—together with the normal facilities that the average practitioner had in his surgery.

The General Secretary reported that the Department of Health had forwarded prescriptions sent by a member of Parliament to the Minister for Health asking that they be referred to the Association "for inquiry as to why the doctor cannot write a prescription to enable his patient to take advantage of the free medicine scheme". The reply was obvious—that a doctor should prescribe for his patient any drug which he thought he might need. If he did not wish to prescribe a drug on the free list, there was no obligation on him to do so.

Some suggestions had been received from the New South Wales Branch and the South Australian Branch requesting that certain preparations should be included amongst the pharmaceutical benefits of the Pensioner Medical Service. Some of these had been included, but it was pointed out that such items as plaster bandages could not be included.

Members of the Federal Council were reminded that at an interview with the Minister he had agreed that drugs from the British Pharmacopoeia of 1948, at present forming part of the pharmaceutical benefits under the Pensioner Medical Service, would not be deleted from the benefits, notwithstanding that in some cases they had been deleted from the British Pharmacopoeia of 1953. The President of the Federal Council had written to the Minister asking for his official confirmation of his intentions. The General Secretary read a reply from the Minister in which he stated that he proposed to adopt officially the British Pharmacopoeia of 1953 and that appropriate action was being taken to include those drugs in the Pharmacopoeia of 1948 which did not appear in the 1953 edition. There would be no material departure from the present basis of benefits.

The General Secretary reported that he had written to the Director-General of Health asking that reprints of the schedule of drugs for both Pharmaceutical Benefits and Pensioner Pharmaceutical Benefits might be issued to medical practitioners. A reply had been received from the Director-General that although there had been some delay, this was unavoidable and reprints were available.

Reference was made to the reported liberalization of the means test for pensioners. The executive members of the Federal Council had had a conference with the Minister on October 10, 1953. At this conference the Minister's attention had been drawn to statements which had appeared in the daily Press of October 9 to the effect that the means test had been liberalized and that pensioners would now be able to earn up to the basic wage. It was stated that the Minister had been reminded of the decision of the Federal Council that the whole Pensioner Medical Service would have to be reconsidered if the means test was liberalized, and that it was more than likely that the matter would be discussed at the forthcoming meeting of the Federal Council. The President had asked the Minister if he could secure any information as to the increase of number of pensioners that would result from any liberalization of the means test. The Minister had replied that he would try to seek to discover whether figures could be secured. Several members of the Federal Council drew attention to the fact that the numbers reported to be affected varied with the medium in which the information was given. In the public Press the number had been stated to be something near 100,000. In *Hansard* it was said to be 27,000. The Federal Council had been given to understand that the number would possibly be 5000. Whichever figure was correct, there was no doubt that a liberalization was intended. Dr. H. R. R. Grieve pointed out that the number of pensioners would increase. There would be further liberalization. If the profession went on accepting the liberalization, where was the point at which the whole basis of professional practice would be altered? Conditions should not be allowed to drift. Some members of the profession thought that the present lists should be frozen, and that only replacements should be admitted when vacancies in the lists occurred. Dr. Grieve thought that the solution was for the Government to pay for any new persons whom they wished to admit to the scheme the share

which they would have to pay to a medical benefits society. In ten years' time many changes would be made, and the increase in numbers would be partly due to the increasing numbers of the population in the old age group. Dr. H. C. Colville reiterated a previous remark of his that the limit had already been reached in regard to numbers. Dr. W. F. Simmons said that a protest would have to be made regarding the ten to twenty thousand new persons who wished to be admitted. Dr. T. Giblin said that in his opinion the Federal Government had broken its contract. Dr. Colville agreed with Dr. Giblin. Dr. L. R. Mallen referred to the suggestion that contributions should be paid for these persons to medical benefits funds. He did not think that this was possible because most of the persons concerned suffered from some chronic illness and would not be accepted by any medical benefits fund. At least half of them, he would think, would come under this category. After further discussion, the Federal Council resolved that the Minister should be informed that as the entitlement to old age and other pensions had been materially liberalized by the Commonwealth Government, the agreement to attend pensioners at fees of 9s. and 11s. for three years from January 1, 1952, had automatically become subject to review. A discussion took place on the general effects of the liberalization of the means test and of the steps that might be taken to safeguard the interests of the profession in such an event. On the other hand, it was stated that those who were already in—the new pensioners who had recently been admitted—would have to be accepted. However, it was pointed out that this kind of thing might be repeated over and over again, and that there was no knowing where it would stop. The view was expressed that it was useless to set a dead line—a date beyond which no further admissions would be accepted. The Government would never agree to accept two classes of pensioners. It was also pointed out that any group of pensioners who were suggested for admission to the Service would include numbers of persons who were genuine pensioners and against whom no objection could possibly be raised. Eventually, the Federal Council adopted a series of four resolutions as follows:

That the Minister be informed that as the entitlement to old age and other pensions had been materially liberalized by the Commonwealth Government, the agreement to attend pensioners at fees of 9s. and 11s. for three years from January 1, 1952, had automatically become subject to review.

That the Minister for Health be informed that the Federal Council is of the opinion that the recent liberalization of the means test for pensioners has reached a point beyond which the Government has no claim on the medical profession for a concessional service.

That the Federal Council inform the Minister for Health that its representatives would be prepared to discuss with him any alternative form of medical service for new groups of pensioners which he may propose, made eligible through future liberalization of the means test.

That the Federal Council is opposed to any extension of a system in which the patient does not pay part of the fee.

That the personnel of the committee to confer with the Minister for Health be as follows: Dr. A. J. Collins (President), Dr. H. C. Colville (Vice-President), Dr. H. W. Horn, Dr. H. R. R. Grieve, Dr. W. F. Simmons, Dr. Charles Byrne, Dr. L. R. Mallen, Dr. H. L. Cook, Dr. T. Giblin and Dr. J. G. Hunter (General Secretary), and that the executive officers have power to appoint substitutes in the event of any of the foregoing being unable to attend conferences.

The General Secretary reported that he had received a request from the Minister for Health asking for the inclusion in the Pensioner Medical Service of approximately 500 aliens, all of whom were destitute. The Federal Council agreed that these persons should be included. Further reference was then made to the proposal for the inclusion of blind persons who had previously been mentioned. It was decided that the question of their inclusion should be deferred until after a discussion had taken place with the Minister.

Provision of Medical Benefits in a General Medical Service.

The Federal Council had before it a letter from the Minister for Health in regard to forms of account for the

medical benefits scheme. The Minister referred to the view expressed by the Federal Council that in the case of consultations and visits the account form should show only the commencing date of treatment of each patient and the number of visits or consultations. He explained that if the date of each service was not shown, the smooth operation of the scheme would be affected and he would be grateful if the Federal Council would give this matter reconsideration. The responsibility of determining the validity of contributors' claims rested on the organizations and the date of service permitted a check against possible double payment of claims. It also enabled services during a waiting period and those rendered when a contributor was unfinancial to be segregated from services for which the contributor was eligible for fund benefit. From the point of view of the Commonwealth the date of each service was required, particularly in the early stages of the scheme, in order to differentiate between the services rendered before the commencement of the scheme and those rendered afterwards. The Commonwealth benefit would not be payable for services rendered prior to acceptance of a person to membership of a registered organization. The General Secretary said that the Minister's letter had been forwarded to the Branches and replies had been received. The South Australian Branch and the Western Australian Branch were opposed to the view put forward by the Minister, but the other Branches regarded his viewpoint as reasonable. After discussion, it was resolved that the position should be reviewed in twelve months' time.

A discussion took place on the furnishing of information by medical practitioners to registered medical benefit organizations. It was resolved that the Federal Council should reaffirm its policy that for the purpose of providing uniformity of information by medical practitioners to registered medical benefit organizations the profession could not agree to the disclosure of the nature of the illness without the authority of the patient.

A discussion took place on the raising of fees. The General Secretary read a letter from the Tasmanian Branch in which was quoted an example of insurance entitlement for work normally done by a consultant on a specific type of case. The work referred to was at present "thrown in" for a smaller fee because of the economic circumstances of the average patient in the State. In order to recover the full amount covered by insurance, the present fee would have to be raised. It was the Association's policy that there should be no raising of fees, but it was put forward by the Tasmanian Branch for consideration of the Federal Council that any modification of the present fees that did not prevent the patient from recovering 90% of the fee was not considered to be contravening the principle that fees should not be increased. The General Secretary said that the matter had been referred to the Branches and that they had disagreed with the Tasmanian Branch's contentions. Dr. D. E. Copping, on behalf of the Western Australian Branch, emphasized the view that the Tasmanian Branch's contention was wrong. Dr. H. W. Horn insisted that the schedule of benefits was one of benefits for patients and not for doctors. It was also pointed out in discussion that such procedures as the estimation of the haemoglobin content of the blood, the microscopic examination of the urine, the fluoroscopic examination of the chest, and even the taking of an electrocardiogram were sometimes part of the normal examination undertaken by a consultant physician. It was eventually resolved that the Federal Council should adhere to the principle that fees should be stabilized and it was strongly of the opinion that in no case should the fee be influenced by the Commonwealth schedule of benefits.

A discussion took place on the method of payment of medical benefits. Reference was made to Subsection 2 of Section 23 of the National Health Bill. The Subsection is as follows:

(2) Commonwealth benefit is not payable in respect of a professional service specified in the First or Second Schedule to this Act unless the registered medical benefits organization has paid the amount of the fund benefit (if any) payable in respect of that professional service and an amount equal to the amount of the Commonwealth benefit payable under this Part in relation to that professional service—

- (a) where the amount of the medical expenses incurred has been paid by, or on behalf of, the contributor—to the contributor or the person who made the payment on behalf of the contributor; or
- (b) in any other case—to the person to whom the medical expenses are payable on behalf of the contributor.

The General Secretary reported that he had written to the Minister stating that a great deal of dissatisfaction

existed in the profession in regard to this subsection. He added that there was a strong desire on the part of the profession that Subsection (b) should apply only in exceptional cases. The Minister was asked to reconsider this matter with a view to making it plain in the Act that this method of payment would apply only in exceptional cases. In his reply, the Minister stated that Subclause (b) was designed to make it clear that the Commonwealth benefit authorized in the previous subclause was payable in two ways, namely, (a) where the patient had paid his account—by way of refund to him, (b) where the patient had not paid his account—by way of payment to doctor or other person, such as medical partnership, to whom the debt was due. In the majority of cases Subclause (a) would apply. However, there would be exceptional cases in which the patient was unable to finance the doctor's account, and to meet this position Subclause (b) had been inserted to provide the machinery whereby the doctor could, in fact, receive the cash. The Minister thought that this section was absolutely essential for the smooth working of the scheme. In the discussion, reference was made to a proposal of the Victorian Branch. The Victorian Branch statement was brought before the Federal Council after it had been discussed by the representatives of the friendly societies. It stated that there was agreement that direct payment would have to be made in cases of financial hardship, and it had been decided that the only way to ensure that this method would not be used unless genuine financial hardship was involved was to make an arrangement whereby it would be a little difficult for both the doctor and the patient. It would be necessary for the patient to obtain a special form from his benefit organization; the doctor would not have supplies of the forms. On this form the patient would state that payment of his total fee would involve financial hardship. The doctor would certify that he believed the statement to be true. He would also be asked to fill in particulars of his fee and certify that part of the fee had been paid to him. The sum paid would have to be stated, but the actual amount would be purely a matter of arrangement between the patient and the doctor. The Victorian Branch expressed the view that the extra trouble involved under the aforesaid machinery for both the patient and the doctor in cases of hardship would deter them from using the direct method of payment except in genuine cases. After discussion, the Federal Council resolved that the Minister for Health should be urged to have placed in the *National Health Act* the following provisos: (a) that the combined government and organization benefit should never be in excess of 90% of the doctor's account for a particular item; (b) that except when hardship was involved, payments should be made to the patient as a refund on presentation to the Medical Benefit Organization of the doctor's receipted account. It was also resolved that if legal difficulties made the inclusion of these provisos in the Act impracticable, there should be provision in the Act that they should be made a condition of registration of Medical Benefit organizations. The Federal Council also resolved that the Minister for Health should be asked to provide in the Act that a claim for benefits under the Medical Benefits Scheme might be filled in and signed only by a contributor or his direct representative, who should not be a person otherwise interested, such as the doctor submitting the relevant account or an officer of a medical benefit organization.

A communication was received from the New South Wales Branch asking for clarification of paragraphs 4 and 5 of the preamble of the outline of Commonwealth Benefits Scheme and schedule of benefits forwarded by the Commonwealth Department of Health in regard to services rendered by nurses and physiotherapists at the request of the medical practitioner. The Minister had explained that payment would be made only when treatment was given by the medical practitioner himself.

The General Secretary reported that the President had received from the Acting Honorary Secretary of The Royal Australasian College of Physicians a letter dealing with an approach made by the College to the Minister for Health in regard to the provision made for specialist or consulting physicians in the schedule, and the apparent anomalies that existed vis-à-vis the other branches of the profession. At a special meeting of the Council of the College it had been resolved that representation should be made to the Minister for Health with a view to obtaining a larger rebate under the Medical Benefits Bill for patients referred to a specialist physician by another practitioner for a clinical medical opinion, and a larger rebate for a specialist physician when called by another practitioner to visit a patient in consultation. The President said that he thought the College had acted unwisely, but at the same time he explained that the College was under no obligation to inform the Federal

Council of what it had done. The writing of the letter by the College to the Federal Council was a courteous action. The letter had been sent to the several Branches, and several of them had expressed regret at the action of the College. As far as was known, the Minister had not replied to the communication of The Royal Australasian College of Physicians and the impression prevailed amongst members of the Federal Council that the Minister desired to deal with only one body. The General Secretary referred to an arrangement made several years previously by the Royal Australasian College of Surgeons and The Royal Australasian College of Physicians that they would not take active part in medico-political discussions. (See *THE MEDICAL JOURNAL OF AUSTRALIA*, April 24, 1943, page 375.) The Federal Council resolved that it should reaffirm its previous policy that it should be the one negotiating body to act on behalf of the profession, and that letters should be sent to all colleges and associated bodies drawing their attention to this. It was also resolved that a letter should be written to The Royal Australasian College of Physicians to the effect that it was recognized that anomalies existed in the schedule of benefits, and that efforts had already been made to have these corrected. It was further resolved that the former letter of the Federal Council to the College and the latter's reply thereto should be again referred to, and that an urgent request should be made that the arrangement involved should be adhered to.

The Federal Council had before it a list of suggested amendments to schedules of Commonwealth benefits. These lists had been drawn up by the Branches and other bodies. The General Secretary said that the lists had been sent to the Minister for Health. After discussion, the Federal Council resolved that approval should be given to the action of the Executive Committee in forwarding the list of anomalies in the schedule of benefits to the Minister for Health. It resolved also that a standing committee should be appointed by the Federal Council which should constantly revise anomalies or make suggestions of alterations to the Commonwealth benefits under the schedule of the *National Health Act*. It suggested that this coordinating committee might have referred to it any suggestion by Branch councils. It further resolved that the President, Dr. A. J. Collins, Dr. H. R. R. Grieve, Dr. W. F. Simmons, Dr. A. J. Murray and the General Secretary, Dr. J. G. Hunter, should be members of the committee. The Federal Council resolved that, in its opinion, the machinery as set out in the instructions, "Commonwealth Medical Benefits", page 13 (Aftercare), should be given a trial to see how it worked out, rather than that an attempt should be made to make any special definition at the present meeting.

The Federal Council considered the statutory committees in connexion with the National Health Services. It had before it a letter from the Western Australian Branch in which it was stated that the best interests of all concerned would be served if each State in the Commonwealth was represented on such a committee. The General Secretary said that he had referred this matter to the Branches. The Queensland Branch had expressed the opinion that the widest representation was desirable, but at the same time, the most essential was the securing of the most able personnel. The New South Wales Branch did not support the view of the Western Australian Branch. The Victorian Branch thought that representation by each State on Federal committees would be impracticable and that no alteration of the present arrangement was necessary. The South Australian Branch thought that the arrangement suggested by the Western Australian Branch would be too unwieldy and was therefore impracticable. The Tasmanian Branch was opposed to the view of the Western Australian Branch.

The General Secretary reported that the President had received a letter from the Minister for Health stating that he had formally established a Federal Advisory Council on Medical Benefits. He asked the President, as a matter of urgency, to nominate a member of the Federal Council to this advisory council. He stated that the council would have the following composition: two representatives of friendly societies, two representatives of medical benefits funds, one representative of the Federal Council of the British Medical Association in Australia, one representative of the Government and one representative of subscribers. The Minister thought that hospitals would probably also be represented. The President said that as the matter was one of urgency, he had agreed to act for the Federal Council. The Federal Council approved of the President's action and appointed him as representative of the Federal Council on the Federal Advisory Council of Medical Benefits.

Dr. C. O. F. Rieger presented a report on a conference of representatives of the Federal Council with representatives

of the Medical Benefits Societies held at Sydney on May 9, 1953. The report was received.

The General Secretary reported that a communication had been received from the Tasmanian Government Insurance Office, Hobart, announcing its intention to inaugurate a medical benefits scheme, and requesting the Tasmanian Branch to give some guide to the amount of benefits which the scheme should provide, so that the account for attendance and treatment by doctors would be met by the Commonwealth and organization benefits funds combined up to, say, 90% of the charge. The President had decided that no information should be given to the Tasmanian Insurance Office. Dr. T. Giblin said that an approach had been made to the Tasmanian Council. It was thought that such a move by the Government might be a preliminary to the fixing of fees in Tasmania. The Tasmanian Government was paying 200% of the government benefits. The President's action was approved.

Mention was made of statements in the public Press of July 23 and 25, 1953, by Senator W. P. Ashley, alleging undue influence by the British Medical Association in the organization of the Medical Benefits Fund of Australia. Replies had been made by the President and by Dr. H. R. R. Grieve, the chairman of the Medical Benefits Fund of Australia. The replies were noted.

It was noted that the Commonwealth National Health (Medical Benefits) Service had been introduced as from July 1, 1953, and that the regulations under the existing National Health Service Act had been gazetted on March 12, 1953.

The General Secretary reported that he had received from the Minister for Health a copy of the report of Mr. W. McNary and Mr. E. A. van Steenwyk, of the United States Voluntary Health Insurance, on their visit to Australia and of the meetings which they had addressed.

National Health Bill.

The General Secretary reported that the National Health Bill had been brought into Parliament by the Minister for Health on March 27, 1953. The Minister had forwarded to the Federal Council copies of his second reading speech.

The General Secretary reported that he had visited Branch councils in April, 1953, to explain the provisions of the Bill. Members of the Federal Council expressed appreciation of the General Secretary's visits and of their value to members of the Branches.

The Federal Council had before it a report by the General Secretary of a conference between the President and General Secretary with the Minister for Health at Sydney on May 14, 1953. Among the matters dealt with at the conference was "professional service". The Minister was asked whether it was intended to pay benefits to patients who were in hospital, either as in-patients or as out-patients. It was pointed out to him that it would be wrong to admit persons to out-patient departments who were members of contributory schemes, as they could receive medical attendance from a private practitioner. The only exception to this rule would be in the case of patients who were referred to the out-patient department for special investigation. The Minister, in reply, had said that he had no intention of paying benefits to patients in hospitals. Among the other matters dealt with at the conference were anaesthetics, the payment of Commonwealth benefit, the penalty clauses in respect of pharmaceutical benefits, and committees of inquiry. In July, 1953, the General Secretary received from the Victorian Branch a letter in which grave concern was expressed regarding the statement of the Minister that he had no intention of paying benefits to patients in hospitals. The Victorian Branch expressed the view that hospitals should be entitled to collect the appropriate refund on behalf of the honorary medical staff in respect to injured patients receiving treatment at a public hospital, as was done in the case of workers' compensation and third party insurance patients. It also resolved that the General Secretary should be requested to take the necessary steps to reopen this matter with the Minister. At a conference with the Minister held on October 10, 1953, the subject had been raised. The President had said that it was desired to have a clarification of the statement that no benefits would be payable to contributors who occupied beds in public hospitals. He interpreted this as meaning that the restriction applied only to contributors who were in public beds, and not to patients who were classified by hospital authorities as paying patients. The Minister, in reply, said that the President's interpretation was correct. No benefit would be payable to the contributor who occupied a public bed in a public hospital. If a contributor was classified as a paying patient, and the hospital authority gave the attending practitioner the right to charge for his

services, then a benefit would be payable to such a patient. Indeed, if a hospital authority decided to classify all contributors to medical benefits organizations as paying patients, then benefits would be payable to all such patients. The President had then referred to the question of out-patients, and to the fact that in some cases benefits were being paid for X-ray and pathological services in out-patient departments. The Federal Council was opposed to such payments, as it would open the door wide for abuse of the whole scheme. No benefit should, he thought, be payable in respect of out-patient services. The Minister, in reply, had said that he was seized with the importance of the question raised by the President and could readily see that it might lead to abuse. However, there were occasions when the out-patient department of a public hospital, for example, in the country, might be the only place where an X-ray examination could be made, and so some arrangement should be possible whereby, under such conditions, the benefit would be payable. He finally agreed that no payment should be made for out-patient services, but that in special cases he might authorize such payment.

The Federal Council had before it a series of objections to provisions of the Bill which had been made by some of the Branches. One of these was dealt with in the conference with the Minister on October 10, 1953. One of the matters discussed had to do with the refund system of payment. It was felt that the only system of payment dealt with in the relevant section should be the refund system, and that a separate clause should be introduced providing for cases of hardship. It was also suggested to the Minister that the section of the Bill dealing with the rules of medical benefit organizations should contain a proviso that the rules of every approved organization must contain a clause providing that in a combined benefit—organization and government benefit—payment to a contributor should not exceed 90% of a doctor's account. It had been pointed out by Dr. H. C. Colville at the conference that the only method of policing the scheme was by the patient himself, and the only motive that could actuate him was self-interest. In other words, he must have a financial interest in the transaction—if it cost him money to consult a doctor, he would not do so unnecessarily and for the same reason would not tolerate over-visiting by the doctor. It was therefore essential that the patient should always have some part of the doctor's fee to pay.

A communication was received from the President of the Federal Council of the Pharmaceutical Society of Australia, asking that consideration should be given to the inclusion of the British Pharmaceutical Codex in lieu of the British Pharmacopoeia in the National Health Bill. It was resolved that in view of the action of the Minister for Health in defining in the National Health Bill the British Pharmacopoeia as including the British Pharmacopoeia, 1948, the proposal of the Pharmaceutical Society of Australia for the replacement of the British Pharmacopoeia by the British Pharmaceutical Codex could not be approved, but that the proposal of the Society that all tablets and injections for the Pensioner Medical Service should come under a list, and that there should be no extemporaneous prescribing of such items, should be approved. A proposal of the Federal Council of the Pharmaceutical Society of Australia for the establishment of an accreditation committee for pharmaceutical benefits was referred to the Branches for consideration. The General Secretary reported that copies of a legal opinion obtained by the New South Wales Branch of the provisions of the National Health Bill had been forwarded to the Branches.

Reference was made to the subject of the certificate of hospitalization (Form HB21). The General Secretary reported that he had written to the Director-General of Health, stating that the certificate in question required the nature of the illness from which the patient was suffering to be stated when a claim was made for the payment of hospital benefits. The letter went on to state that apart from the fact that the nature of the illness became known to lay members of the hospital staff, through whose hands the certificate passed, it was often not in the interests of the patient that his illness should be known to him. The Federal Council therefore asked that the Form HB21 should be amended to provide that the diagnosis should be filled in by the patient, who should give authority to his medical attendant to confirm the diagnosis if necessary. A reply had been received from the Director-General of Health stating that careful consideration had been given to the Federal Council's proposal. The Director-General stated that the matter primarily concerned registered hospital benefits organizations and accordingly had been discussed with the principal organizations in the four States. These organizations had

unanimously expressed the view that it was most desirable that the nature of the illness continued to be stated in this certificate. They contended that accurate information in this regard was essential for the proper assessment of claims, and most organizations strongly opposed the suggestion that this information should be given by the patient in his claim. Their grounds for this view were abuse, confusion, and increased work by organizations and by doctors who would be pestered by patients seeking medical certificates. The organizations had pointed out that this information had been required by certificates used by them prior to the introduction of the Commonwealth scheme. In the circumstances, it was considered that the adoption of the Federal Council's proposal would tend to endanger the successful operation of the scheme. It was resolved by the Federal Council that no further action should be taken in the matter.

The Federal Council considered a request by the Western Australian Branch for the consideration of ways and means of bringing the Federal Council hospital policy into operation. This request had been made in October, 1952. The General Secretary said that the queries in the Western Australian letter had been submitted to the several Branches and the replies had been received. These questions dealt with the number of private, public and intermediate beds, the possible effect of the Commonwealth Government's hospital scheme on these numbers, the ability of doctors to follow their patients into hospital, the question of open and closed hospitals, and the effect on teaching hospitals. The Federal Council discussed these replies and resolved to reaffirm its hospital policy as laid out at a meeting on March 1, 1949, as follows:

That the Branch councils be informed that it is the opinion of the Federal Council, where public hospitals are available free to all members of the community, and the whole financial responsibility for their upkeep has been accepted by the Government, no reason exists for the continuation of honorary service.

That public hospitals should be open to, and provide accommodation for all classes of patients—public bed, intermediate and private—according to their means, and that intermediate and private patients should pay for medical attention.

That all reputable medical practitioners should be entitled to render services to intermediate or private patients in all public hospitals and that Branch councils be asked to implement this policy.

Dr. Leigh Cook said that an Australian-wide solution would be the best in the long run. The provision of more private and intermediate beds would affect teaching hospitals, particularly in regard to patients who could be used for teaching purposes. The question of a closed or private hospital was important. Ways and means should be discussed. If public hospitals had private beds and remained closed institutions, it was conceivable that most hospitals would be closed hospitals. This would result in the same deterioration as had occurred in Great Britain. For this reason alone, discussion of the problem was important. The General Secretary explained that the matter was really one for the several States, and that it was the province of each State to implement its own policy. In New South Wales the idea of community hospitals was fostered. Some hospitals were open and some were closed. The policy was that all hospitals should be open so far as private and intermediate accommodation was concerned. Dr. C. O. F. Rieger said that in Adelaide, in the Adelaide and Children's Hospitals they were pressing for the institution of intermediate and private beds. In these circumstances the question of retention of the honorary system arose. After further discussion, the Council resolved to reaffirm its hospital policy.

Campaign Against Tuberculosis.

At its previous meeting, in February, 1953, the Federal Council discussed the campaign against tuberculosis in the light of a communication received from the College of Radiologists of Australasia. The Council of the College forwarded copies of resolutions adopted at its meeting of August, 1952. The resolutions were as follows:

The Council approves in principle of genuine cases having tuberculosis case surveys.

The Council insists on the application of the means test to all out-patients referred to the X-ray department of a private hospital in those States where the means test is at present in being.

The Council is willing to cooperate in genuine tuberculosis case-finding schemes, provided that its

administration is entirely disassociated from hospital X-ray clinical departments.

This examination should be confined to primary detection of cases of pulmonary tuberculosis and that the report should be limited to those usually given in such case-finding schemes; that is, "normal", "probably normal", or "faulty film".

The Council decided that all films should be reported on by a recognized radiologist. The Federal Council approved these resolutions in principle. The General Secretary reported that he had received a letter from Dr. H. W. Wunderly, Commonwealth Director of the Division of Tuberculosis. In his letter, Dr. Wunderly asked for an explanation of some of the expressions used in the resolutions of the College of Radiologists. The General Secretary said that the President had replied to Dr. Wunderly's letter. In this letter, he said that the phrase "general cases having tuberculosis case survey" referred to follow-up investigations necessary to establish a first diagnosis. The effect of this was that the Federal Council agreed with the Federal Council of the College of Radiologists that investigation in a survey up to the point of diagnosis should be free to the patient. The second resolution was quite consistent with the foregoing and indicated the condition that survey patients should not be mixed up with patients sent for investigation and treatment from the medical public and from other departments of the hospital. The fourth resolution, which Dr. Wunderly had stated would be difficult to implement in Australia, was one which the President proposed to discuss again with his Council. After discussion of these letters and of other matters connected with them, the Federal Council resolved as follows:

That the Federal Council recommend to the Minister for Health that X-ray examinations at public hospitals of the chests of applicants for entry into the Commonwealth Public Service be excluded from the scope of the tuberculosis survey, and that a fee be payable for the services to the practitioner rendering the report.

That, in the opinion of the Federal Council, radiologists holding salaried appointments in public hospitals should be entitled to extra payment for work done in connexion with tuberculosis surveys.

That the Federal Council is of the opinion that the principle whereby radiologists are employed by hospitals at a fixed salary and for which they are expected to examine private, intermediate and workers' compensation cases without the right of being able to charge for the investigations is contrary to the policy of the Association.

The Federal Council had also before it a request by the College of Radiologists of Australasia that the Council should seek an increase from £3 3s. to £4 4s. for a session consisting of 250 small films or 25 large films, and, further, requesting that this fee be made uniform throughout the Commonwealth. The General Secretary said that this matter had been referred to the Branches, and that they were all in agreement with the suggestion. It was pointed out in discussion that the examination of small films, though a large number could be reported on in a relatively short space of time, was very wearying and that the time came when the radiologist had to rest from sheer inability to continue the work. The Federal Council resolved that the request of the College of Radiologists that the Federal Council seek the increase asked for should be approved.

Form of Administration.

The Federal Council had before it a communication from the New South Wales Branch forwarding for consideration a copy of a memorandum prepared by Dr. C. E. Cook when he was Commissioner of Public Health in Western Australia. Consideration of the document was deferred.

Australasian Association of Psychiatrists.

The Federal Council had received from the Australasian Association of Psychiatrists a schedule of fee which it proposed to adopt. It was pointed out that the fixing of fees in private practice in any branch of medical activity was not a function of the Federal Council.

Publicity Committee.

The Publicity Committee of the Federal Council was reappointed as follows: Dr. A. J. Collins, Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. E. Lee, Dr. L. R. Mallen and Dr. C. H. Dickson.

A Therapeutic Substances Act.

At a previous meeting of the Federal Council it was resolved that it should be a recommendation to the Minister for Health that he should introduce a *Therapeutic Substances Act* for the purpose of ensuring that pharmaceutical products should conform to an approved standard. The General Secretary reported that he had written to the Minister in terms of the Federal Council's resolution, and he had also asked the Minister that consideration might be given to requesting manufacturers of pharmaceutical substances to produce proof to the Department of Health of their claim in respect of substance by means of a certificate from an approved laboratory that the product fulfilled the claim made for it, or that it conformed to the prescribed standard. The General Secretary read a reply from the Minister in which he stated that a conference had been held to consider means whereby the respective powers of the Commonwealth and the States could best be mobilized to provide for adequate control by complementary legislation and administrative cooperation. A number of resolutions had been adopted by the conference. These included:

1. A recommendation for the establishment of a Commonwealth Standards Laboratory to police prescribed standards of quality.

2. A recommendation that the Commonwealth Government should, to the limits of its constitutional powers, bring down legislation relating to the standard of purity of drugs used as therapeutic substances.

3. A recommendation that the States bring down complementary legislation of a uniform pattern to provide for the licensing of the manufacture of therapeutic substances.

4. A recommendation for the establishment of an expert committee to advise the Commonwealth and States of suitable standards for therapeutic substances not included in the British or other recognized pharmacopœias.

5. A recommendation that the Commonwealth and States jointly, within the powers of their respective constitutional powers, take the necessary legislative and administrative action with respect to the marketing and labelling of the therapeutic substances, as was from time to time deemed necessary to give particular effect to the preceding.

6. A definition of therapeutic substances as follows: " . . . any substance or mixture or compound of substances or biological product which is intended to be administered or applied, whether internally or externally, to persons for the purpose of preventing, diagnosing, curing or alleviating any disease, ailment, defect or injury, or for the purpose of testing susceptibility to any disease or ailment in man or animals, or for the purpose of altering physiological processes."

7. A recommendation that the States extend the definition of "drug" in existing State drug legislation to include all substances embraced by the Commonwealth definition.

8. A recommendation that the States take power for the Governor-in-Council to prescribe certain therapeutic substances, the manufacture of which should be subject to licence, this list to include those substances proclaimed by the Commonwealth under its *Therapeutic Substances Act*.

The Minister concluded his letter by stating that action in the direction of preparing draft legislation for the States could not be undertaken until the final form of Commonwealth legislation was known. Meanwhile, a bill to provide the powers required by the Commonwealth was being prepared. The General Secretary said that he had sent this information to the Branches.

Ophthalmological Society of Australia (British Medical Association).

The Federal Council received Dr. A. L. Tostevin as a deputation from the Ophthalmological Society of Australia (British Medical Association) which sought the help of the Federal Council in some of its difficulties. Dr. Tostevin presented a memorandum in which it was stated, *inter alia*, that the Society was increasing in membership and was developing activities which would make strict adherence to the rules of membership increasingly difficult. An Australian Institute of Ophthalmology was to come into being and its registration in Canberra had already been effected. The

scientific workers of the Institute should be eligible for membership of the Ophthalmological Society. Dr. Tostevin pointed out that an analogous position existed in regard to the Institute of Ophthalmology in the United Kingdom, where such workers as physiologists and physicists who were not medical graduates were members of the Ophthalmological Society of the United Kingdom. Applications for membership of the Ophthalmological Society had been received from New Zealand and the United Kingdom and the Society was looking for ways and means of opening its doors or membership to both these units of the Commonwealth as well as to South Africa. The Ophthalmological Society thought that it might achieve its object by the creation of new categories of membership or by alteration of the rules governing special groups within the Association. It hoped that the Federal Council might be able to suggest some variation of the rules to facilitate the development of the Ophthalmological Society along the lines indicated, even if the making of such variations made necessary reference to the Parent Body in England. The members of the Council asked Dr. Tostevin several questions about the Ophthalmological Society, and the General Secretary referred to the Articles of Association of the British Medical Association and pointed out that it was possible for any medical or non-medical person resident in Australia to be made a complimentary member of one of the Branches of the Association and that such a complimentary member might then be elected to membership of a special group, and as a member of the special group he would be subject to any of its rules and regulations. After Dr. Tostevin had withdrawn, the Federal Council resolved that the matter of helping the Ophthalmological Society in its efforts to expand its activities should be left in the hands of the President and the General Secretary.

Special Groups.

A communication was received from the Otolaryngological Society of Australia asking for views on a suggestion that otolaryngologists in New Zealand might be included in the Society. It was resolved that the Federal Council should offer cooperation and the General Secretary undertook to explain what could be done.

Australasian Post-Graduate Federation in Medicine.

The General Secretary reported that the sixth annual general meeting of the Australasian Post-Graduate Federation in Medicine was held on October 13, 1953. The Federal Council had been asked to send a representative, and Dr. T. Y. Nelson, President-Elect of the New South Wales Branch, had agreed to represent the Federal Council, but, unfortunately, at the last moment, he had been prevented from attending.

A Fund for the Publication of Monographs.

At the last meeting of the Federal Council, to a suggestion that a fund should be established for the publication of monographs which could not be published in *THE MEDICAL JOURNAL OF AUSTRALIA*, the matter had been brought to the notice of the Federal Council by the Editor of the journal, and the Federal Council had approved the suggestion. Dr. A. J. Murray and Dr. W. F. Simmons had been appointed trustees of the fund and they had been requested to submit a report on the matter at the next meeting of the Federal Council; the Editor of the journal was co-opted as a member of the subcommittee to do this. The following report by the trustees was presented to the Federal Council:

1. That the fund be known as the Federal Council Medical Monograph Fund.

2. That the object of the fund shall be the publication of monographs of a high standard on the medical and allied sciences on behalf of authors who are unable to bear the cost of publication.

3. That each monograph shall be inscribed "Medical Monograph of the Federal Council of the British Medical Association in Australia, Number X".

4. That the Federal Council shall appoint three trustees to administer the fund.

5. That the trustees shall have powers of cooption for special purposes.

6. That monographs submitted for consideration be scrutinized by the trustees and the Editor of *THE MEDICAL JOURNAL OF AUSTRALIA*, and that they shall determine whether the advice of special referees is necessary.

7. That as a general rule not more than two referees be selected to advise the trustees.

8. That the referees shall preferably have had no association with the work presented in the monographs.

9. That the referees be paid an honorarium, the amount of which shall be determined by the trustees.

10. That the monographs shall be edited and published by the Australasian Medical Publishing Company, Limited (no charge shall be made by the company for the editing).

11. That the presentation of the copy for the monographs shall in general be that required for THE MEDICAL JOURNAL OF AUSTRALIA.

12. That the proceeds of the sales of the monographs be paid into the fund unless otherwise determined by the trustees.

13. That in the foregoing clause the question of payment of a royalty to the author shall not be lost sight of.

14. That steps be taken to secure contributions to the fund.

The Federal Council decided to receive and adopt the report. It then decided that a Federal Council Medical Monograph Fund should be established and that donations to the fund should be invited. It resolved that a banking account, to be known as the Federal Council Medical Monograph Fund, should be opened at the Commercial Banking Company of Sydney, Limited. Dr. A. J. Collins was appointed a trustee of the fund. The Federal Council resolved that a letter of appeal for donations to the fund, over the signature of the President, should be published in THE MEDICAL JOURNAL OF AUSTRALIA.

British Medical Association.

Overseas Subscriptions.

The General Secretary reported that the Parent Body had made a supplementary grant of 4s. 6d. to the previous capitation grant of 6s., making a total capitation grant of 10s. 6d. in respect of each subscription. This meant that the Australian Branches were paying to London £1 11s. 6d. in respect of each member.

Annual Meeting of the Association at Cardiff, 1953.

It was reported that Dr. W. W. S. Johnston, C.B.E., D.S.O., M.C., E.D., and the General Secretary, Dr. J. G. Hunter, had attended the annual meeting of the Association at Cardiff on July 13 to 17, 1953.

Constitution of the Representative Body.

The General Secretary reported that he had received from the Winchester Division a copy of a memorandum on the constitution of the Representative Body of the British Medical Association.

Scholarships in Aid of Scientific Research.

The General Secretary said that he had received from the London office copies of posters relating to the Ernest Hart and Walter Dickson scholarships in aid of scientific research.

British Medical Conference, 1955.

The General Secretary reported that he had received from Dr. A. Macrae, the Honorary Secretary and Treasurer of the British Commonwealth Medical Conference, a letter stating that it had been decided to hold the next conference at Toronto, Canada. Dr. Macrae explained that the suggestion had been made that the conference should be held in London, but this would have been difficult to arrange as the annual meeting of the Association was to be held in Toronto in association with the Canadian Medical Association. The arrangement of a British Medical Conference in these circumstances would be much easier if it was held in Canada, and Toronto had therefore been adopted as the venue. The Federal Council resolved to accept this proposition.

World Medical Association.

The General Secretary reported that he had received from the Secretary-General a copy of the minutes of the 17th Council meeting of the World Medical Association, held at Lisbon, Portugal, on May 22 to 27, 1953. He had also received from Dr. L. R. Mallen a brief report of the meeting. Copies had been circulated to the Branches and to members of the Federal Council. The General Secretary had also received from the Secretary-General a copy of the report of the Planning and Finance Committee.

The Secretary-General of the World Medical Association had sent a copy of the minutes of the 6th General Assembly, held at Athens, October 12 to 16, 1952.

The Secretary-General had forwarded credential cards and copies of the agenda and documents to be considered at the 7th General Assembly at The Hague, Netherlands, on August 31 to September 5, 1953. A report on this Assembly had also been received from Dr. L. R. Mallen and Dr. J. G. Hunter, delegates of the Federal Council to the Assembly.

Dr. L. R. Mallen reported on the eighteenth Council meeting, held in London on August 18 to 22, 1953, and on the nineteenth Council meeting held at The Hague on September 6, 1953.

It was noted that the 8th General Assembly was to be held at Rome in October, 1954. At a previous meeting of the Federal Council, it was resolved that Dr. H. C. Colville should be the Australian representative at the meeting. Dr. Colville explained that, unfortunately, he was unable to accept the assignment and was compelled to decline the honour. The Federal Council resolved that Dr. H. Leigh Cook should be the Federal Council's representative for 1954.

The Secretary-General had written advising that invitations to member associations wishing to be host at the 10th General Assembly would be considered at the 7th General Assembly at The Hague, August 13 to September 5, 1953. The General Secretary said that Turkey was anxious to have a General Assembly, and he reminded members of the Federal Council that Australia had been mentioned as a possible venue for the General Assembly in 1955. Cuba had also been mentioned.

Dr. J. G. Hunter, the General Secretary, presented a report on the first world conference on medical education, held in London on August 22 to 29, 1953. This conference had been arranged by the World Medical Association. Dr. Hunter's report was before the Federal Council and he spoke about it and referred to the extreme value of the gathering. He also mentioned the report of the conference in the *British Medical Journal*.

A communication had been received from the Secretary-General of the World Medical Association advising that in future a registration fee of the equivalent of ten dollars (United States) would be charged to all persons other than two delegates, two alternative delegates and two observers attending the General Assembly and desiring to participate in social functions.

The Secretary-General had also submitted a proposal that during the General Assembly sessions each member association that had one of its members on the Council should pay the *per diem* allowance of such a member during a General Assembly session. This proposal was approved by the Federal Council.

The Secretary-General had written advising the decision of the 6th General Assembly that the membership subscription to the World Medical Association would be increased by 50% for 1954 and by another 50% for 1955, with a maximum subscription of 10,000 Swiss francs. Dr. W. F. Simmons said that some concerted action should be taken in order to provide funds for the World Medical Association. In New South Wales appeals had been made to the local associations. He asked whether anything had been done in other States. One of the Queensland representatives said that a committee had been appointed in Queensland, and one of the South Australian representatives said that a committee had been appointed in South Australia. Dr. Charles Byrne said that Victoria had appointed a committee. Dr. D. E. Copping expressed the opinion that the World Medical Association should be "sold" to members of the Association in Australia, and the President expressed the opinion that the members of the Federal Council should take part in any efforts that were made. It was suggested that if every member of the Association subscribed one guinea a year there would be no trouble whatever about funds.

A communication was received from the Secretary-General forwarding a copy of a statement by Dr. L. A. Hulst, President of the World Medical Association, on experiments on human beings. The statement was received.

The Secretary-General sent an inquiry asking what was the approximate number of young practitioners who were working without remuneration. A reply had been sent to him that as far as was known, no medical practitioners in Australia worked without remuneration.

A letter was received from the Secretary-General forwarding a copy of a communication received from the World Health Organization, requesting comments on its recent expert committee's report on non-proprietary names of drugs. The Secretary-General also sent a copy of a request

received from the World Health Organization for advice in preparing the second edition of the International Pharmacopoeia. It was resolved that Dr. Byron Stanton, of Melbourne, be requested to comment on the second edition of the International Pharmacopoeia which was being prepared by the World Health Organization.

Reference was made to the principles of social insurance, and also to a notice of motion which had been given by Dr. L. R. Mallen, as follows: "That the Commonwealth Government and the Opposition party be advised that the Federal Council is not in accordance with the policy set out in the document published by the International Labour Office, namely, No. V(a)2 'Minimum Standards of Social Security'." It was pointed out that the Executive Board of the World Health Organization had indicated that the document prepared by the World Health Organization consultant group did not necessarily represent the opinion of members of the Board and should not be taken as an expression of policy by the World Health Organization, and it was resolved that nothing should be done in regard to Dr. Mallen's notice of motion for the time being. The Federal Council also had before it a report of the Social Security Committee of the World Medical Association by Dr. Dag Knutson.

The General Secretary, Dr. J. G. Hunter, reported that he had been reappointed Secretary of the World Medical Association for Australia.

National Health and Medical Research Council.

Further reference was made to the thirty-fourth Session of the National Health and Medical Research Council which was held at Canberra from November 7 to 19, 1952, and to the discussion that took place in regard to sufferers from Hansen's disease. At its last meeting, the Council resolved that a request should be made to the Minister for Health that the same social service benefits should be allowed to sufferers from Hansen's disease as were allowed to sufferers from tuberculosis. The General Secretary reported that he was still awaiting a reply from the Minister.

The General Secretary said that Dr. W. F. Simmons, the Federal Council's representative on the National Health and Medical Research Council, had asked for any business which should be included in the agenda for the thirty-fifth Session which was held at Sydney on May 20 and 21, 1953. Dr. Simmons remarked that it was unfortunate that very often requests for subjects to be brought forward at a meeting of the Council were left until the last possible moment, and that this added greatly to his difficulties. The Federal Council also had before it a report by Dr. Simmons of the proceedings of the thirty-fifth Session. This report was received by the Council, and the President formally thanked Dr. Simmons for it and expressed his appreciation of the value of the work which Dr. Simmons had done for several years on behalf of the Federal Council.

Commonwealth National Fitness Act, 1941.

The General Secretary said that he had received a report of the activities of the Commonwealth National Fitness Department for the year 1951.

Commonwealth Health Department.

International Congress on Medical Librarianship.

The General Secretary, Dr. J. G. Hunter, presented a report of the International Congress on Medical Librarianship which he had attended as a representative of the Federal Council. He remarked that a full report would be issued at a later date.

Pakistan Medical Association Central.

The General Secretary said that he had received from Dr. L. L. Davey, the Federal Council's representative to the Congress of the Pakistan Medical Association Central, a report of the proceedings. Dr. Davey's report was received and a letter from him was read in which he described the liberal hospitality which had been extended to him in Pakistan. It was resolved that a letter should be sent by the General Secretary to thank the Pakistan Association for their treatment of the Federal Council's delegate.

The Control of Cortisone.

The General Secretary reported that, acting on the instructions of the Federal Council, he had written to the Minister for Trade and Customs asking that in view of the great importance of cortisone, and having regard to the fact that it was not manufactured in Australia, the existing restrictions on its use should be discontinued and an increase

in its importation be permitted. A reply had been received from the Minister for Trade and Customs stating that he had referred the matter to the Director-General of Health. The Director-General of Health had received advice from The Royal Australasian College of Physicians to the effect that its Therapeutic Advisory Committee was of the opinion that cortisone should be released from Commonwealth control, but that it should be supplied only on prescription and in such quantities as a legally qualified medical practitioner had directed. With regard to the importation of the drug, the Minister stated that at all times licences had been freely granted and the demands of wholesale druggists and private individuals were, from a licensing aspect, being adequately met.

International Cancer Congress.

The General Secretary said that he had received a communication from the Director-General of Health stating that the sixth International Cancer Congress would take place in Sao Paulo, Brazil, in July, 1954. The Secretary-General of the International Anti-Cancer Union, Paris, had issued an invitation to delegates from Australia, and had indicated that he would forward copies of the provisional agenda to those interested.

Toxic Hazards Associated with the Use of Poisonous Substances in Agriculture.

The General Secretary said that he had received a letter from the Director-General of Health inquiring whether information giving expert advice on toxic hazards associated with the use of poisonous substances in agriculture had been sent to medical practitioners in Australia. The General Secretary said that he had forwarded to the Director-General of Health a copy of a pamphlet entitled "Dangerous Organic Phosphorus Insecticides" sent to members of the New South Wales Branch in August, 1951, and supplied by the New South Wales Department of Health.

A Radioactive Substances Act.

The General Secretary reported that he had received from the Acting Director-General of Health a letter in which mention was made of a proposed *Radioactive Substances Act*. Accompanying the letter was a copy of the draft Act dealing with the subject, and the Acting Director-General of Health said that he would welcome any views which the Federal Council of the British Medical Association might offer. The General Secretary reported that a copy of the letter and of the draft Act had been sent to the Branches. The Federal Council adopted a motion approving of the proposed Act for the control of radioactive substances and certain apparatus producing radiation, and it was of the opinion that a member of the College of Radiologists of Australia and New Zealand should be a member of any radiological council established under the Act.

International Congress of Cardiology.

The General Secretary said that he had received a notice in regard to the second International Congress of Cardiology, which was to be held from September 12 to 15, 1954.

The Canberra Community Hospital.

The General Secretary reported that the President had received a request from the Director-General of Health and the Minister for Health asking that he would visit Canberra to advise on problems of administration of the Canberra Community Hospital. The President said that he had visited Canberra, that he had given advice, and that as far as he knew the advice had been accepted.

A communication was received from the College of Radiologists of Australasia asking for consideration and possible action on the position of radiologist at Canberra Community Hospital. In its letter the College stated that, apart from the question of underpayment and overwork which characterized the appointment of a radiologist to the Canberra Hospital, the whole setup was very unsatisfactory from the point of view of the College. In the first place, the services of the radiologist were available to anyone without any means test. Secondly, the radiologist received no share of the fees. Thirdly, the operation of his services was such as to eliminate any possibility of private radiological practice in Canberra, and a paid or salaried radiologist was being substituted as a public service. Fourthly, the radiologist was also required to include insurance, governmental and, presumably, repatriation work in his duties. After the New South Wales representatives and those from Western Australia had described problems in

their States connected with radiological practice, Dr. D. E. Copping said that the College had unloaded the problem on to the Federal Council and that he hoped the Council would be able to help them. It was resolved that the matter should be left in the hands of the President and General Secretary.

Repatriation Department.

Medical Benefits for Widows, Widowed Mothers and Orphans of 1914-1918 and 1939-1945 Wars.

The General Secretary reported that he had received a communication from the Chairman of the Repatriation Commission advising of the rates payable for the financial year 1953-1954 for the treatment of widows, widowed mothers and orphans of the two world wars. The rates were as follows: for the metropolitan area £3 14s. 6d. and for country areas £4 12s. A letter was received from the New South Wales Branch reaffirming its previous decision that all services to repatriation beneficiaries other than those rendered at out-patient clinics and at hospitals should be on a fee-for-service basis. This decision had been sent to the Branches. Queensland was in agreement with the New South Wales Branch. The South Australian Branch agreed and the Victorian Branch agreed. The Western Australian Branch opposed the New South Wales view. The question was raised whether forms would have to be filled in if a fee-for-service basis was adopted. The reply was that, of course, forms would have to be used. In favour of the fee-for-service basis, it was stated that it was wrong to oppose the proposal because the capitation rate was fairly high and because practitioners were unwilling to do paper work. After further discussion, the Federal Council resolved that all services to repatriation beneficiaries other than those rendered at out-patient clinics and at hospitals should be on a fee-for-service basis. The Tasmanian representatives explained that they did not vote on this motion because opinion in the Tasmanian Branch was evenly divided on the matter.

Emergency Treatment at Week-Ends and Holidays.

At the previous meeting of the Federal Council, a discussion took place at the instance of the Tasmanian Branch in regard to the emergency treatment of repatriation patients at week-ends and holidays. The Federal Council then decided that the question should be referred to the Branches. The Queensland Branch had replied that the time for such a proposal was inopportune. The New South Wales Branch thought that the fee should be £1 1s. for attendances after hours at night time and week-ends and on holidays. The Victorian Branch thought that such extra fees should not be sought. The South Australian Branch thought that an additional fee of 7s. 6d. might be sought for attendance on repatriation patients on public holidays and week-ends. The Western Australian Branch thought that a flat rate for week-ends and holidays should be £1 1s. The Tasmanian Branch thought that the fee for week-end visits should be raised to £1 1s. The Federal Council resolved that a fee of £1 1s. should be sought for emergency attendance after hours, at night time, at week-ends and on holidays.

Form 70 (Prescriptions).

It was resolved that discussion on Form 70 (Prescriptions) should be deferred.

Consultation at Specialists' Rooms.

Reference was made to the fee charged for consultation at the rooms of specialists. A letter was received from Sir Arthur Fadden, the Commonwealth Treasurer, in which he stated that he approved of the payment of an increased fee of £2 10s. as from July 1, 1953, for the first visit, and of £1 1s. for each subsequent visit to be paid to all doctors with recognized specialist qualifications who examined at their rooms patients referred to them by Commonwealth departments. The fee previously payable had been £1 1s. The general opinion was expressed that the fee was inadequate, and the Federal Council resolved to inform the Treasurer that the fee of £2 10s. offered by him for consultant's service in their rooms to patients referred to consultants by Commonwealth Government department was inadequate, and that in the opinion of the Federal Council it should be increased to £3 3s. for the first visit, with £2 2s. for subsequent visits, these being the fees usually charged in private practice.

The Federal Council had before it some correspondence which had been passed between the Australian Association of Neurologists and the Chairman of the Repatriation Com-

mission. The Association had asked for an increase in fees. The fee which had been paid for many years was £2 2s. The Association asked for an increase in the fee on account of the length of time taken for neurological examinations. They also asked to be remunerated for appointments which were not kept by ex-soldiers; this was a matter of frequent occurrence and occasioned considerable monetary loss to the neurologist. The Federal Council discussed this at some length and resolved that the Branches should be asked to give consideration to the question of the time factor in relation to specialists' fees.

Fees Paid to Visiting Specialists.

A letter was received from the Western Australian Branch requesting a review of the rates for sessional payments for specialist services in Repatriation hospitals. The General Secretary said that the matter had been referred to the Branches and the replies had been received. After discussion, the Federal Council resolved that the Repatriation Department should be approached with a view to having fees for sessional payments to specialists attending Repatriation hospitals increased to £4 4s. for the first hour or part thereof and 10s. 6d. for every subsequent half-hour or part thereof.

Fees Paid to Radiologists.

The General Secretary reported that he had received a copy of a letter forwarded to the Repatriation Commission on December 18, 1952, submitting a schedule of X-ray fees adopted by the College of Radiologists of Australasia for use by their members in relation to services to ex-service personnel for whom responsibility was accepted by the Department of Repatriation. With the letter and the scale of fees was enclosed a copy of a reply received from the Chairman of the Repatriation Commission advising that the schedule had been adopted by the Department.

Fees Paid to Medical Practitioners on Assessment Appeal Tribunals.

The General Secretary reported that he had received a letter from the South Australian Branch in regard to the fees payable to medical practitioners sitting on assessment appeal tribunals for the Department of Repatriation. The South Australian Branch stated that, as far as it was aware, the fee paid for this service, namely, £5 5s., had not been altered since the inception of the tribunals in the early 1920's, and in view of the fact that there had been a general increase in other fees since that time, it was felt that an increase in the fee payable for this procedure was considerably overdue. The South Australian Branch suggested that the Federal Council might take appropriate action. The General Secretary reported that he had referred the South Australian letter to the Branches and had received replies. In most instances the fee suggested for the future was £10 10s. It was therefore resolved that the Federal Council was of the opinion that the fee payable to medical practitioners sitting on assessment appeal tribunals for the Department of Repatriation should be increased from £5 5s. to £10 10s.

Salaries Medical Officers.

The General Secretary referred to the salaries paid to medical officers in the Department of Repatriation and to the application to the Commonwealth Arbitrator for a variation of the award. He said that the whole matter was bound up with the question of marginal increases and that no decision had yet been reached.

Medical Officers of the Armed Forces and Their Conditions of Service.

The General Secretary reported that he had received a letter from the Director of Naval Medical Services seeking information in regard to the average income of medical practitioners in Australia. The General Secretary explained that this was not information easily obtained, and that he could only base his estimate on inquiries made some years before. He had, however, informed the Director that the average net income of a general practitioner was about £3000 per annum. The Secretary's action was approved.

Fees for Examination of Applicants for Admission to the Commonwealth Public Service.

The Secretary referred to the fee payable to local Commonwealth medical officers for the examination of applicants for admission to the Commonwealth Public Service. He said that he had not been able to make any progress so far.

The fee of £1 5s. was grossly inadequate; the comparable fee for life assurance examination was £2 2s. The General Secretary stated that he hoped to have a decision before very long.

Form R6 of the Department of Social Services.

The General Secretary reported that he had received a request from the New South Wales Branch that the Federal Council should approach the Department of Social Service to have the fee for the completion of Form R6 increased from £1 1s. to £2 2s., and also that the Department should be requested to have a form of consent from the application attached to the form. The matter had been referred to the Branches, and Victoria, South Australia, Western Australia and Tasmania had supported the New South Wales view. The Queensland Branch thought that perhaps £1 11s. 6d. would be suitable. The Federal Council adopted the New South Wales suggestion and decided to make representation to the Department of Social Services for an increase in the fee to £2 2s., and also to have a form of consent from the patient attached to the form.

Commonwealth Employees' Compensation Act.

The General Secretary reported that he had received a letter from the Queensland Branch in which was enclosed a letter from the Secretary of the Department of the Navy Office in Melbourne. In the Navy's letter, reference was made to the schedule agreed to by the Queensland Branch and by the authorized insurance under the *Workers' Compensation Act*, and it was stated that it would be appreciated if consideration could be given to the inclusion in this agreement of the Department of the Navy, in so far as both services and civilian members of the Department were eligible for treatment under the *Commonwealth Employees' Compensation Act*. The General Secretary read a letter which he had sent to the Queensland Branch. In this he stated that there was no agreement with the Commonwealth for employees' compensation in regard to rates for attendance by medical practitioners or Commonwealth employees entitled to the benefits of the *Commonwealth Employees' Compensation Act*, 1930. Attempts had been made to secure such an agreement, but the reply had always been that the time was inopportune. Letters from each of the other Branches were read, and it was resolved that the General Secretary would investigate this schedule and would bring up the subject for consideration at the next meeting of the Council.

National Service Medical Examinations.

The General Secretary said that he had received from the Department of Labour and National Service copies of a recent amendment to the booklet "Instructions for Medical Examination".

The Registration of Alien (New Australian) Medical Practitioners.

The General Secretary reported that the President had received a letter from the Secretary to the Department of Immigration in which reference was made to the merits of the qualifications of former displaced persons wishing to practise as members of the medical profession in Australia. The Secretary of the Department reminded the President that discussions had been held between the Federal Council and representatives of the Department of Immigration and of Labour and National Service. At that discussion, departmental officers undertook to compile statistical information on the qualifications and experience of European doctors seeking registration. The Secretary now forwarded the results of these investigations. The result was a classification of displaced person doctors based on an analysis of their professional history. The request was made for the Federal Council to consider this information with a view to participating in discussions with representatives of the Immigration Planning Council at a date which could be decided upon to meet the convenience of all concerned. This classification included reference to 287 male and 63 female displaced persons claiming European medical qualifications and who were resident in Australia. They were divided into nine categories. The matter had been referred to the several Branches and the replies of the Branches were read. The Queensland Branch replied that the classification list did not in any way alter the original opinion of the Federal Council that nothing should be done which would lower the standard demanded for medical practitioners in Australia. The New South Wales Branch left the matter in the hands of its representatives on the Federal Council. The Victorian Branch reaffirmed a previous resolution: that, as the matter

of alteration of conditions of the registration of alien practitioners was purely a matter for the States, the Victorian Branch Council was of the opinion that the Federal Council should not proceed further in the matter, but should recommend to the Federal Government that it be referred to a meeting of representatives of State registering bodies. The Victorian Council thought that the Federal Council should be prepared, however, to advise on any aspect of the problem within its competence. The South Australian Branch Council expressed the view that the classification drawn up by the Department was quite useless in view of the fact that no reference was made to the standard of medical training which these persons had received. The South Australian Branch Council went on to state that during the discussions on the matter, Dr. L. R. Mallen had stated that the American Medical Association had recently given very careful consideration to this question, and in an endeavour to assess the type of medical training which these European graduates had received, had compiled a list of European universities considered by the first-mentioned body as being of the standard required as accredited teaching schools for medical practitioners. The Council therefore suggested that steps might be taken by the Federal Council to secure a copy of the classification compiled by the American Medical Association. The Western Australian Branch replied that the information supplied did not help in the forming of an opinion on this problem, and in any case, it considered that the matter was one which should properly be dealt with by the medical registration authorities in the several States. The Tasmanian Branch Council was of the opinion that any person in this group of alien medical practitioners should pass an examination comparable with that of an Australian university, and that only those who had acquired degrees prior to the war and qualified before 1939 should be accepted for examination. The President remarked that the Federal Council had never committed itself on this matter. The matter was one which really should be dealt with by boards appointed for the purpose. The plain fact was that an *ad misericordiam* appeal was being made. The question was whether this group of persons should be subjected to a special examination. If the Federal Council thought that this was a hard luck story, it should say so. If the present mechanism was sufficient it should also say so. Dr. H. R. R. Grieve said that the only people competent to assess the qualifications of the persons concerned were the medical boards of the States. After further discussion, the Federal Council resolved that it was firmly of the opinion that the question of the examination of credentials and registration of displaced doctors was a matter for decision by the State registering bodies and should be referred to them. The Federal Council, however, was vitally concerned with the standard of training required of the medical graduate in order that the health of the people of Australia might be safeguarded. It considered that any relaxation of the present registration requirement in the States would be detrimental to these standards.

The Federal Council also resolved that the President, Dr. A. J. Collins, Dr. H. R. R. Grieve, Sir Hugh Poate and the General Secretary, Dr. J. G. Hunter, should be appointed as a committee to meet the Immigration Planning Council.

The Capacity of the Medical Profession in Australia to Absorb New Members.

The General Secretary referred to a review which had been made recently by Sir Hugh Poate on the capacity of the medical profession in Australia to absorb new members. He said that copies of this article had been sent to the Branches and to members of the Federal Council. The article was published in *THE MEDICAL JOURNAL OF AUSTRALIA* of October 17, 1953, as a "Special Article".

Identification of Ampoules, Solutions and Packages of Dangerous Drugs Used in Anaesthetic and Surgical Practice.

The Federal Council considered a request by the New South Wales Branch in regard to the identification of ampoules, solutions and packages of dangerous drugs used in connexion with anaesthetic and surgical procedures. The matter had arisen at an ordinary meeting of the New South Wales Branch held in December, 1952, when papers were presented on anaesthetic injuries. At the end of the discussion at the Branch meeting the following resolution was adopted:

That the matter of standardization and patterns for identification of ampoules, solutions, and packages of dangerous drugs used in anaesthetic and surgical practice be referred to Council with a

request that it recommend to the Federal Council that the matter be taken up with the World Medical Association.

The New South Wales Branch Council had decided to accede to the request and had forwarded the resolution for consideration by the Federal Council. The General Secretary said that the matter had been referred to the Branches. The Queensland Branch agreed with the New South Wales Branch's recommendation. The Victorian Branch also supported the New South Wales view, but added that the Federal Council should also refer the matter to the Pharmaceutical Benefits Advisory Committee. The South Australian Branch supported the New South Wales view, but added that it would be advisable for the Federal Council also to communicate with the Director-General of Health requesting him to bring the matter under the notice of the World Health Organization. The Tasmanian Branch also agreed with the New South Wales view, and the Western Australian Branch did likewise. The Western Australian Branch added a comprehensive statement traversing the whole subject. This statement was divided into 13 clauses. Unfortunately, limitations of space prevent the reproduction of this statement. The Federal Council decided to recommend to the World Medical Association that a method of standardization and patterns for identification of ampoules, solutions and packages of dangerous drugs used in anaesthetic and surgical practice should be devised. Dr. L. R. Mallen interposed that the matter was not really one with which the World Medical Association would concern itself. It was rather a matter for the World Health Organization. To this the reply was made that the World Medical Association was the body with which members of the practising profession communicated, and the World Medical Association might well hand it on to the World Health Organization.

The Fluoridation of Drinking Waters.

At its previous meeting, the Federal Council, having received a letter from the Australian Dental Association, discussed the fluoridation of drinking waters as a method of reducing dental caries. After discussion, the Federal Council resolved to defer consideration of the matter. Dr. A. E. Lee said that the Federal Council was in no position to make a decision on the matter. Dr. H. R. R. Grieve said that the background of training of medical men was sufficient reason to enable them to come to a reasonable decision on the matter. He referred to the editorial which had been published in *THE MEDICAL JOURNAL OF AUSTRALIA* on October 17, 1953, and said that in his opinion the Federal Council should support an investigation of the desirability of the adoption of the measure in the Commonwealth. Dr. W. F. Simmons pointed out that Dr. N. E. Goldsworthy was carrying out an investigation and that the National Health and Medical Research Council was interested in it. The Federal Council resolved that it was prepared to support the Federal Government in an investigation by competent scientific authorities into the question of fluoridation of drinking water.

The Immunization of Dogs Against Distemper.

At its previous meeting, the Federal Council considered the immunization of dogs against distemper as a result of a letter which had been received from the Victorian Branch conveying the views of one of its members. This member thought that where veterinary surgeons were not available, provision should be made for the injection of dogs with serum by other persons, such as pharmacists. The view was expressed that pharmacists could be taught by medical practitioners how to give the injections. The Federal Council had resolved that the Minister should be informed of a suggestion of the Victorian Branch member. The General Secretary reported that he had written to the Minister, setting out the proposals of the member as amended by the Federal Council. They were as follows: (i) In towns or districts where the services of a veterinary surgeon are not available, the doctors could form a committee for the purpose of teaching and instructing the pharmacists and chemists of their town in ways of injecting the living virus. (ii) The doctors were to act purely in a teaching and advisory capacity. (iii) The doctors were to receive no payment for any work or advice they gave. (iv) The chemists were to make no charge for any injections they gave, but could charge for the product they sold. The General Secretary also stated in his letter that he understood that a conference had been held with the Minister and that the Minister had agreed to the proposal. The General Secretary read a reply from the Minister stating that it was incorrect that he had agreed to the proposals put up to him. He had agreed at the conference that pro-

posals of this kind might be submitted to the British Medical Association by the Branch member and that then the matter would be again considered on receipt of a reply. The Minister was aware that in New South Wales no one but a registered veterinary surgeon could undertake the treatment of an animal such as a dog. He concluded his letter by saying that he had received a letter from the President of the Victorian Branch of the Australian Veterinary Association on the subject of distemper immunization by persons other than veterinary surgeons and he was hopeful that the Veterinary Association would provide a satisfactory solution of the problem under consideration. The members of the Federal Council expressed the hope that the Victorian Branch of the Australian Veterinary Association would proceed with the matter.

International Conference of Experts on Pneumonokoniosis.

The General Secretary reported that he had received a copy of the proceedings of the third International Conference of Experts on Pneumonokoniosis, held at Sydney in February and March, 1950. The proceedings, which comprised two volumes, had been forwarded by the Occupational and Safety Health Division of the International Labour Office, Geneva.

The Regional Council in Australia of the Royal College of Obstetricians and Gynaecologists.

The General Secretary reported that he had received a letter from the Acting Honorary Secretary of the Australian Regional Council of the Royal College of Obstetricians and Gynaecologists. In this letter it was stated that a diploma in obstetrics of the College was not of specialist standing and was awarded to registered medical practitioners who had had special post-graduate training and experience in obstetrics only. The *Medical Act* of Queensland stated that any post-graduate diploma in a specialty issued by a recognized institution was a diploma in the specialty which the Medical Board had to recognize. As a result of this, doctors whose only specialist qualification was the Diploma in Obstetrics were able to register as specialists in Queensland. Correspondence had taken place between the Australian Regional Council and the Medical Board of Queensland and with the National Health and Medical Research Council on this subject, but the College had failed to receive any satisfaction. The Regional Council sought the help of the Federal Council in an approach to the Queensland Government to alter the legislation so that doctors whose only qualification was a Diploma of Obstetrics of the College should not be registered as specialists. The General Secretary said that the matter had been referred to the Branches and that replies had been received. The Queensland Branch had stated that the matter was one of the legal interpretation of the words in the *Medical Act*, namely, "university or other institution approved by the Board" rather than one of the merits of the case. The New South Wales Branch had replied that the matter should be regarded as one with which the Queensland Branch Council should deal. The Victorian Branch had stated that the matter concerned only one State, and that the Council was not prepared to express an opinion on a Federal basis. At the same time, the Branch Council was of the opinion that it would be reasonable to suggest that a body such as the Royal College of Obstetricians and Gynaecologists should not admit candidates to a diploma which it did not regard as carrying specialist status. The South Australian Branch had replied that the remedy lay in the hands of the College itself, since it was considered that there was no purpose in a practitioner undertaking specialist training of a special nature unless the diploma obtained by him gave him the status of a specialist in the particular category concerned. The Western Australian Branch had replied that, in the absence of more detailed information, it was unable to express an opinion on the matter. The Tasmanian Branch had replied that if the College concerned did not consider the diploma to be one of specialist status, its views should be endorsed. After further discussion, the Federal Council resolved that as the Diploma in Obstetrics of the Royal College of Obstetricians and Gynaecologists was granted by the College after the fulfilment of prescribed conditions and examination, the Federal Council could not agree to recommend to the Queensland Government that it be not recognized for the purpose of specialist registration.

The Registration of Locum Tenentes in Queensland.

The General Secretary read a letter from the Queensland Branch enclosing a communication from the Under Secretary for the Department of Health and Home Affairs of Queens-

land. In this letter, attention was drawn to the fact that some medical practitioners who had accepted locum tenencies at country hospitals in Queensland had not become registered as medical practitioners of the State. Such a practice was illegal and difficult situations might arise when medical practitioners failed to register. The Minister asked the Queensland Branch to bring the matter to the notice of the Federal Council. The General Secretary stated that he had sent the information on to the Branches with a request that they should notify their medical agents in their respective States of the Under Secretary's contention.

Ships' Surgeons.

Further reference was made to the remuneration of ships' surgeons. It was stated that the salary at present payable was £850 *per annum*, and the ship's surgeon was permitted to charge 12s. 6d. per visit to first class passengers and 10s. per visit to second class passengers. The General Secretary stated that he had had an interview on the matter with the chairman of the Australasian Steamship Owners' Federation. The chairman had stated that he appreciated the point of view of the ship's doctor, but said that his position applied also to other officers of the ship. Not infrequently it happened that the ship's captain received less than the second or third engineer. So acute was the position in regard to shipping around the Australian coast, that it had been found necessary to take off some ships, and unless conditions improved more ships would have to be taken off. The Federal Council resolved that, for the time being, no further action should be taken.

The Queensland Branch had sent a letter from the surgeon of an Australian coasting vessel inquiring whether he was bound to supply information regarding patients to the master or his deputy, and inquiring for a ruling on the matter. It was pointed out that Rule 133 of the regulations of the shipping company in question provided that the surgeon should present a statement of the sick daily to the master, and at the same time should make any special report that might be necessary. The view was expressed that it was not necessary that a diagnosis should be included.

Income Tax and Social Services Contribution Assessment Act.

The General Secretary reported that he had received a letter from the South Australian Branch drawing attention to the allowance granted by the Taxation Department in the case of a principal who supplied either his assistant or his locum tenens with board and lodging. The present allowance made for deduction purposes was £1 per week. The South Australian Branch stated that the deduction allowed by the department had remained unaltered for the previous twenty-five years, and that the present-day cost of supplying an assistant or locum tenens with board and lodging made it imperative that a more realistic view of the position should be taken by the Taxation Department. The General Secretary said that he had referred the matter to the Branches and that they all supported the view of the South Australian Branch. The Federal Council resolved that information should be sought as to the cost of board and lodging of a locum tenens so that appropriate approach might be made to the Commissioner of Taxation for the purposes of obtaining an increased allowance deductible by the principal for income tax purposes.

The General Secretary also reported that he had received from the Queensland Branch a letter regarding the fee payable to Commonwealth medical referees for examination of "invalid relative", namely, 10s. if the examination was conducted in the office or surgery, and 15s. if the examination was made in the patient's home. It was considered that this fee was inadequate for such a certificate, and the Queensland Branch Council asked the Federal Council to take steps to have the rate altered to comply with the fee paid for invalid pensioner examination, namely, £1 for examination in the surgery and £1 5s. for examination in the home. The General Secretary said that he had referred the matter to the Branches and that they had all agreed that an increase should be made. It was resolved that a request should be made to the Commissioner of Taxation for increase in the fee payable to Commonwealth medical referees for examination of an invalid relative for whose maintenance a deduction was claimed under the provisions of Section 82(B) of the *Income Tax and Social Services Contribution Assessment Act, 1951*.

War Service Homes.

The General Secretary stated that the Victorian Branch had drawn attention to the fact that when a practitioner had recently sought financial assistance from the War Service Homes Department, it had been informed that within the terms of its legislation, the department was compelled to restrict its loans to property of a maximum value of £3000, on which, however, £2000 could be advanced. The Victorian Branch Council thought that this was an anomalous position, in that it would be impossible, on present values, to obtain any medical residence for the sum of £3000. After the members of the Federal Council had heard the views of the Branches on this matter, and further discussion had taken place, it resolved that representation should be made to the Commonwealth Government that loans on war service homes should be made irrespective of the capital value of the property.

Floods in Britain, Holland and Belgium.

Reference was made to the floods which had taken place in Britain, Holland and Belgium in February, 1953, and to the proposed establishment of funds for relief purposes. During the discussion, it was pointed out that the conditions in Great Britain had been met and that there was now no need for a contribution to be sent from Australia. In any case, in such a matter contributions should be made spontaneously and without delay. In regard to flood relief in Holland and Belgium, it was reported that the New South Wales Branch had made a donation of £100 sterling to the Royal Netherlands Medical Association, and that this gift had been much appreciated. After discussion, the Federal Council resolved that legal opinion should be sought as to the possibility of the Federal Council making donations to funds for the assistance of medical practitioners affected by national disasters.

The Flying Doctor Service of Australia.

Attention was drawn to the recent disaster in Queensland, in which the pilot of a Flying Doctor's plane was killed, and also the wife of a Flying Doctor, Dr. O'Leary. It was resolved that a letter of sympathy should be sent to the Flying Doctor Service of Australia.

The Pink Pages of the Telephone Directory.

A letter was received from the New South Wales Branch forwarding a communication from the Dermatological Association of Australia requesting that an approach should be made to the Postal Department to have the title "Skin Specialist" in the pink pages of the Telephone Directory altered to "Skin Therapists", and recommending that the request be approved. It was pointed out that persons described as "skin specialists" were not medically qualified, and the Dermatological Association thought that if "skin therapist" was the term used, there might be no objection. The Federal Council resolved that the General Secretary should be instructed to write to the Postmaster-General's Department requesting that the classification "skin specialist" should be deleted in the pink pages of the Telephone Directory.

Date and Place of Next Meeting.

It was resolved that the determination of the date and place of the next meeting should be left in the hands of the President.

Votes of Thanks.

The Federal Council resolved that its thanks should be extended to the Council of the South Australian Branch for its hospitality and for the accommodation provided for the meeting, and to Mr. F. W. C. Dobbie for the assistance rendered by him in the arrangements for the meeting.

It was also resolved that the thanks of the Federal Council should be extended to the following for their hospitality: Dr. and Mrs. C. O. F. Rieger, Dr. and Mrs. L. R. Mallen, Dr. and Mrs. Sholto J. Douglas.

The Federal Council also thanked Dr. J. G. Hunter and Miss H. Cameron for their services during the meeting.

The Federal Council recorded a vote of thanks to Dr. A. J. Collins, the President, for having presided at the meeting.

Medical Societies.

NATIONAL ASSOCIATION FOR THE PREVENTION OF TUBERCULOSIS IN AUSTRALIA.

The third annual general meeting of the National Association for the Prevention of Tuberculosis in Australia and the second annual general meeting of its medical section, the Australian Laennec Society, was held in Hobart on October 2 and 3, 1953. The President, Dr. Keith Barry, presided at the annual meetings of the Council and of the Association. The following representatives of individual States were present: Dr. Cotter Harvey and Dr. Bruce White, New South Wales; Dr. W. J. Newing, Lady MacKenzie and Mr. H. Buchanan, Victoria; Dr. Alan King and Mr. A. J. Bishop, Western Australia; Dr. J. V. Duhig, Queensland; Mr. F. Marriott, M.H.A., Mr. C. Collins and Mr. C. S. Barnard, Tasmania, with Dr. J. L. Grove, Mr. B. W. Griffiths and others as observers; Dr. D. R. W. Cowan and Mr. H. C. Dridan (Executive Secretary), South Australia.

The meetings were very successful and much useful business was accomplished. The Honourable the Minister of Health for Tasmania, Dr. M. J. D. Turnbull, gave a stimulating address at the annual meeting and outlined the important work being done in tuberculosis control in Tasmania.

The Australian Laennec Society held a clinical meeting on the evening of October 1 when Dr. Bruce White, the President-Elect, gave an address on tuberculosis control, emphasizing the importance of the Mantoux test in particular. He took, as a text, the message given to practitioners on the blotter prepared by the New South Wales Division, in which the elderly physician always performs a Mantoux test on children and arranges for X-ray examination of the chest of his adult patient. He pointed out that the Mantoux test would have an increasing value in assessing the incidence of tuberculous disease and was the means of implementing the first of three fundamental principles laid down by the World Health Organization in its plan for the control of tuberculosis from a global point of view. In his summary on the value of the X-ray examination as the most important single diagnostic weapon, Dr. White warned against pitfalls awaiting the interpreter. He emphasized that wrong labels could be attached to abnormal shadows and showed X-ray films demonstrating various lesions to illustrate this point. Dr. White had two moving pictures shown illustrating important aspects in the control of tuberculosis. One of these pictures, an excellent colour film, was produced by amateur artists and photographers in Sydney and reflected the greatest credit on all concerned.

At the business meeting of the Australian Laennec Society, Dr. Bruce White (Sydney) was elected as President, Dr. I. O. Thorburn (Perth) as President-Elect and Dr. Alan King (Perth) as Honorary Secretary-Treasurer. Active branches of the Society have been formed in Sydney and Perth, and it is anticipated that similar branches will soon be formed in the other capital cities.

The 1954 meetings will be held in Brisbane. Active steps are being taken to arrange a conference of representatives from Pacific and South East Asian countries for 1955 in Sydney. The Laennec Society has been asked to make preliminary plans for scientific meetings.

Out of the Past.

In this column will be published from time to time extracts, taken from medical journals, newspapers, official and historical records, diaries and so on, dealing with events connected with the early medical history of Australia.

GOVERNOR'S DESPATCHES (1825).¹

13.9.1825.

Sir Thos. Brisbane to Lord Bathurst.
My Lord,

Before my present despatches are closed by the present conveyances there is a subject upon which I have frequently thought it necessary to address your Lordship and to which I beg leave to call your Lordship's serious attention. It is

¹ From the original in the Mitchell Library, Sydney.

the active part taken by many of the surgeons of the Convict Ships in the political proceedings of this colony and their instrumentality in collecting and carrying home materials for the purpose of attacking the local Government through the medium of the opposition papers in London. I have already had occasion to bring the name of Surgeon Hall under your Lordship's notice and his connection with the false and slanderous reports relative to the women at Emu Plains is another additional proof of the active part taken by him in misrepresenting the Government of this Colony—I could also mention other surgeons of convict ships who have not been less active and economical in providing themselves with board and lodging in the colony at the cheap rate of carrying home the materials for slandering the Government and gratifying the private feeling of certain dissatisfied individuals in this colony. There is at present amongst us Mr. George Fairfowl who came as Surgeon Superintendent of the ship "Royal Charlotte" which arrived in this country as far back as the end of April and who I can assure your Lordship from the most correct information took a very industrious part in the late investigation against Dr. Douglas. I think your Lordship will agree with me in opinion that whatever might have been the merits of that case it was very unbecoming in a surgeon of His Majesty's Navy coming here upon a transitory service to have taken any part whatever in the investigation directed by your Lordship. I beg to be understood as not wishing to prefer this as a charge against Dr. Fairfowl but merely as a statement of a fact as one among many others of the same character which appear to me to call for your Lordship's interposition to put an end to by an instruction conveyed through the proper channel.

I have the honour, etc.,

THOS. BRISBANE.

Correspondence.

REHABILITATION AND RESETTLEMENT IN GREAT BRITAIN.

SIR: Dr. Selwyn Nelson (M. J. AUSTRALIA, November 21, 1953) has stressed the deficiencies in the teaching and practice of rehabilitation, revealed by Dr. B. G. Wade in his report on rehabilitation and resettlement in Great Britain. Unfortunately, the teaching of rehabilitation (or physical medicine and rehabilitation, as the specialty is now called) cannot be placed on a sound basis until the teaching hospital contains a properly staffed and equipped department of physical medicine and rehabilitation. Probably the best department of this type is that at King's College Hospital, London, where under its physician-in-charge, Dr. Frank Cooksey, O.B.E., M.D., it has achieved international fame.

Unfortunately again, there is a lack of understanding on the part of some members of the profession (including recent graduates) of the aims and methods of physical medicine and rehabilitation, and even at times a lack of sympathy. This is understandable, for until we have physical medicine and rehabilitation developed in its modern form, the profession at large cannot readily become acquainted with it, and such teaching as there is, though of value, can only be incomplete and rather academic.

As Dr. Nelson points out, the teaching hospital should give a lead. This it cannot do until its physiotherapy department is up-graded into a department of physical medicine and rehabilitation. Examples of somewhat similar departments elsewhere are those of University College Hospital, London (Dr. Hugh Burt), Community Hospital, Copenhagen (Dr. Svend Clemmesen), The Mayo Clinic (Dr. Frank Krusen), and New York University-Bellevue Medical Centre (Dr. Howard Rusk), to name but a few. Such a department combines and integrates, under the physician-in-charge, physiotherapy, occupational therapy, and almoner (social worker) services, and has within easy access X-ray and clinical pathology departments, and brace-maker and surgical boot repair facilities. In Queensland, the Repatriation Hospital has shown the way in the provision of occupational therapy and an almoner department in addition to physiotherapy.

Must Australian medicine repeat overseas mistakes and waste time in learning, slowly and at cost, lessons already learnt? It has been proved conclusively that, in terms of community economy, "rehabilitation pays dividends". It has

been shown in other centres that physical medicine and rehabilitation, far from constituting an inroad on orthopaedics and other specialties, renders the latter valuable assistance, and comes to provide new cases for them.

There are indeed gross deficiencies in the care of the sick, injured and elderly, especially in the period between hospital or medical discharge and return to employment or full living. It is only by means of the medically directed and coordinated facilities of a proper department of physical medicine and rehabilitation that this long-neglected and necessary patient-care can be effectively provided. Such care alleviates hardship and suffering, it prevents unnecessary hospital readmissions, it shortens the period of a worker's unemployment, but it must start soon after the patient is first seen, it must be coordinated, and it must be continued until the patient has, with any needed help, reinstalled himself in the community. This is the practical expression of the definition of this work: the preparation of the patient physically, mentally, socially and vocationally for the fullest possible life compatible with his abilities and his disabilities.

The first essential action, then, in meeting deficiencies in the teaching and practice of rehabilitation, is the establishment by the teaching hospital of an adequate department of physical medicine and rehabilitation. Obviously, such action rests, and waits, upon those empowered, and entrusted, with the financing and management of the teaching hospital.

Yours, etc.,

RODNEY MEYERS.

639 Sandgate Road,
Clayfield,
Brisbane.
November 25, 1953.

A COLLEGE OF GENERAL PRACTITIONERS.

SIR: I wish to notify applicants for membership of the New South Wales Regional Faculty of the College of General Practitioners that application forms are on their way from England, and are expected within a few days. These will be forwarded to those who have already asked for them immediately on their arrival.

Yours, etc.,

D. W. LAWSON,
Secretary.

Main Street,
Cessnock,
New South Wales.
November 30, 1953.

RECENT EXPERIENCES OF THORACIC SURGERY IN NEW SOUTH WALES.

SIR: In answer to Mr. C. J. Officer Brown's letter published in the Journal of November 21, 1953, I would like to point out that my own experience, and the views expressed, are not necessarily representative of New South Wales generally.

Sydney differs from Melbourne in that the hospitals are proportionately greater in number and less centralized geographically. One especial difference is that there is not the almost complete separation of the tuberculosis service from the general hospitals as in Melbourne. Almost all the major surgery for pulmonary tuberculosis in New South Wales (excluding repatriation cases and the Newcastle area) is performed in two general hospitals and the Bodington Chest Hospital, Wentworth Falls. Because of the shortage of these facilities, patients suffering from tuberculosis have been accorded high priority in obtaining treatment in these hospitals.

In Sydney it is planned to make additions to certain general hospitals for the treatment of tuberculosis. I know of no authoritative statement to suggest that these plans should include provision for even a small number of patients with non-tuberculous thoracic disease, although it does not seem reasonable to expect these hospitals to provide a duplicate service for the treatment of such patients. In terms of social justice, how, in fact, can the claims of individual patients be decided, and who is to decide them?

The facts presented in Mr. Brown's letter emphasize certain fundamental truths as regards the future. With present trends in New South Wales, what young man is likely to dedicate himself to a career of extirpative lung surgery for one disease when in a few decades he may find himself physically spent, and financially penniless, having

outlived his usefulness as a thoracic surgeon? Under these circumstances it is possible that the very cause for which so much money is being devoted may be jeopardized ultimately for want of trained persons.

Although one must agree with most of Mr. Brown's comments, it is obvious that the problems in Sydney and Melbourne are very different, and that his final recommendation is not possible at present.

Yours, etc.,

IAN MONK.

135 Macquarie Street,
Sydney,
November 24, 1953.

CORNEAL ULCER.

SIR: In his article on corneal ulcer (October 31, 1953) the author recommends: (a) atropine for all abrasions and ulcers when first seen; (b) pure carbolic acid in preference to iodine for cauterizing; (c) a pad secured by adhesive tape, "Sellotape" or "Durex" for an eye previously cocaineized with 4% cocaine; (d) the use of cortisone.

The article is, presumably, written for general practitioners. Cortisone, without adequate mydriasis, is a dangerous drug, and most surgeons have now seen pupils firmly bound down in cases of iritis so treated. Admittedly the author recommended atropine at the beginning of the treatment, but, in a bad ulcer, its effect will be transitory and may even be quite inadequate. To place a loose pad over a cocaineized eye is most inadvisable; if a pad is to be used it should be firmly bandaged on, preferably with an elastic bandage, otherwise the pad may abrade the cornea.

In the vast majority of ulcers carbolic is quite unnecessary; the iodine mixture (7% iodine, 5% potassium iodide in spirit), which is so much safer, particularly in inexperienced hands, is less painful and quite adequate. Anyone who has seen the destructive effect of a drop of pure carbolic in an eye would hesitate to recommend its use except by the experienced.

Finally, the routine use of atropine in all abrasions and ulcers regardless of their severity is, to use the author's own expression, a "boots and all" technique. If all the 5000 ulcers and abrasions the author treated during the war years were atropinized the loss to national production must have been more disastrous than a general strike. Why not start mydriasis in abrasions and mild ulcers with 2% homatropine? Most of them will never need atropine and the effect will have passed off twenty-four hours after the homatropine is ceased.

Yours, etc.,

JAMES HART.

"Firhall",
131 Wickham Terrace,
Brisbane.
November 27, 1953.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 71, of November 12, 1953.

CITIZEN NAVAL FORCES OF THE COMMONWEALTH.

Royal Australian Naval Reserve.

Appointments.—Grant Pattison and Richard Howell Stanistreet are appointed Surgeon Lieutenants, dated 23rd June, 1953.

Promotion.—Surgeon Lieutenant James Dermott Villiers is promoted to the rank of Surgeon Lieutenant-Commander, dated 2nd March, 1953.

ROYAL AUSTRALIAN AIR FORCE.

Permanent Air Force: Medical Branch.

The following officers are appointed to permanent commissions, 1st September, 1953: Squadron Leader J. F. Howell-Price (023025), Flight Lieutenant R. G. Sharp (023027).

Flight Lieutenant K. M. Woods (023095) is granted the acting rank of Squadron Leader, 10th September, 1953.

The resignation of Flight Lieutenant W. J. Ferguson (025643) is accepted, 7th September, 1953.

Active Citizen Air Force: Medical Branch.

The appointment of Flight Lieutenant (Acting Squadron Leader) J. Beaumont-Haynes (021950) is terminated, 16th September, 1953, on demobilization.

Air Force Reserve: Medical Branch.

The following Air Cadets are appointed to commissions with rank as indicated: ((Flight Lieutenant) No. A4704 Peter Alan Harbison (04704), No. A4706 Gregory Barton Markey (04706), 25th May, 1953; No. A35260 William Percy Austin (035260), No. A35262 John Hasker Learmonth (035262), No. A34702 Albert Ronald Benson (034702), No. A35241 Leonard Clarence Weber (035241), No. A35272 William Henry Taylor (035272); (Pilot Officer) No. A35228 William Murray Mitchell (035228), 12th June, 1953.

The following Air Cadets are provisionally appointed to commissions with the rank of Pilot Officer: No. A4713 Richard Clayton Bennett (04713), No. A4737 Thomas Bruce Berry (04737), No. A4739 Ian Nicholas Broadbent (04739), No. A4715 Robert Brummitt (04715), No. A4717 Bernard John Cox (04717), No. A4742 David Michael Fox (04742), No. A4744 Lewis Clive Harman (04744), No. A4711 Richard John Kimber (04711), No. A4720 James Roland Lawrence (04720), No. A4750 Malcolm Joseph Munday (04750), No. A4756 Bruce Goodman Wark (04756), No. A4712 Robert Neill Munday (04712), 25th May, 1953; No. A34721 John Sugden Woodhouse (034721), No. A35226 John Farquhar MacDonald (035226), No. A34705 John Eugene McCarthy (034705), No. A34703 Stuart John Hunt Shepherd (034703), No. A34709 James Murray Calvert (034709), No. A34794 Peter Francis Bladin (034794), No. A34800 John Alfred Harley (034800), No. A34708 Eric Edward Allchin (034708), No. A34792 Geoffrey William Harley (034792), No. A34707 John Arthur Fuller (034707), No. A34793 Noel McKenzie Bennett (034793), No. A34796 Graham George Farrant (034796), No. A34795 John Graham Downes (034795), No. A34797 Edward William Pick (034797), 12th June, 1953.

Post-Graduate Work.

THE ROYAL INSTITUTE OF PUBLIC HEALTH AND HYGIENE.

THE Royal Institute of Public Health and Hygiene conducts a recognized course of instruction (for post-graduate medical men and women only) for the certificate in public health examination of the conjoint board of the Royal College of Physicians of London and the Royal College of Surgeons of England. This leads to courses for the diploma in public health and for the diploma in industrial health. Students are also prepared for the diploma in industrial health examination of the Society of Apothecaries of London. The next course of instruction for the certificate in public health will commence on March 19, 1954. Further information, entry forms and prospectuses may be obtained from the Secretary of the Institute, 28 Portland Place, London, W.1, or from the Acting Dean at 23 Queen Square, London, W.C.1.

Australian Medical Board Proceedings.

NEW SOUTH WALES.

THE following have been registered, pursuant to the provisions of the *Medical Practitioners Act, 1938-1950*, as duly qualified medical practitioners: Adey, William John, M.B., B.S., 1950 (Univ. Melbourne); Broughton, Peter Percival, M.B., B.S., 1951 (Univ. Melbourne); Caldwell, Norman James, L.M.S.S.A. (London), 1944, M.R.C.S. (England), 1945, L.R.C.P. (London), 1945, D.P.H., R.C.P. and S. (England), 1950; Wallman, Neil Stuart, M.B., B.S., 1944 (Univ. Adelaide); Shagrin, Paul Joseph, M.B., B.S., 1953 (Univ. Sydney); Carter, Ian Dan, M.B., B.S., 1952 (Univ. Adelaide); Hansberry, Gerald Maxwell, M.B., B.S., 1953 (Univ. Adelaide); McCluskie, John Aloysius, M.B., Ch.B., 1925, B.Sc. (Med.), 1926 (Univ. Glasgow); Uren, John Ivan.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED NOVEMBER 14, 1953.¹

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	2(2)	1	..	..	1	..	..	..	4
Amoebiasis
Ancylostomiasis	31	..	4	..	..	..	..	..	35
Anthrax
Bilharziasis
Brucellosis
Cholera
Chorea (St. Vitus)	2	..	..	..	..	..	..	..	2
Dengue
Diarrhoea (Infantile)	5(5)	4(4)	..	..	..	..	..	9
Diphtheria	5(1)	1(1)	2(1)	..	2(2)	..	..	..	10
Dysentery (Bacillary)	2	..	1(1)	..	..	..	3
Encephalitis	1(1)	1	..	..	..	2
Etiarasis
Homologous Serum Jaundice
Hydatid
Infective Hepatitis	13(2)	..	..	6(4)	..	..	..	19
Lead Poisoning
Leprosy
Leptospirosis	3	..	3
Malaria
Meningococcal Infection	3(2)	7(5)	..	..	..	..	..	..	10
Ophthalmia
Ornithosis
Paratyphoid
Plague
Pollomyelitis	13(4)	5(2)	1	4(3)	3(2)	..	..	..	26
Puerperal Fever	1	..	..	..	1
Rubella	18(13)	..	..	56(51)	..	..	..	74
Salmonella Infection
Scarlet Fever	17(12)	12(9)	19(17)	3(3)	..	..	..	..	51
Smallpox
Tetanus	2	1	..	..	..	..	..	3
Trachoma
Trichinosis
Tuberculosis
Typhoid Fever	26(17)	13(8)	13(7)	9(6)	10(4)	4(1)	..	..	75
Typhus (Flea-, Mite- and Tick-borne)	1	..	..	..	..	..	1
Typhus (Louse-borne)
Yellow Fever

¹ Figures in parentheses are those for the metropolitan area.

M.B., B.S., 1952 (Univ. Queensland); Roberts, Cecil Gordon, M.R.C.S. (England), 1930, L.R.C.P. (London), 1930, M.D. (Cantab.), 1939; Humphry, Alfred Henry, M.B., B.S., 1937 (Univ. Adelaide), D.T.M. and H., 1953 (Univ. Sydney); McGlashan, John Gardner, M.B., B.S., 1942 (Univ. Adelaide), D.T.M. and H., 1953 (Univ. Sydney).

The following additional qualifications have been registered: Davis, Eric Lewis (M.B., B.S., 1939, Univ. Sydney), M.R.A.C.P., 1943, M.R.C.P. (Edinburgh), 1953; Jobson, Philip Latham (M.B., B.S., 1935, Univ. Sydney), D.A., 1948 (Univ. Sydney), F.F.A., 1952, R.A.C.S.; Meares, Stanley Devenish (M.B., 1930, B.S., 1932, Univ. Sydney, F.R.C.S. (Edinburgh), 1936, F.R.A.C.S., 1948, M.R.C.O.G., 1936), F.R.C.O.G., 1953.

QUEENSLAND.

The following have been registered, pursuant to the provisions of *The Medical Acts*, 1939-1948, as duly qualified medical practitioners: Sewell, Ian Blamyre, M.B., B.S., 1953 (Univ. Melbourne); Morris, Robert Barry, M.B., B.S., 1952 (Univ. Sydney); Murphy, Andrew John, M.B., B.S., 1952 (Univ. Melbourne).

The following additional qualifications have been registered: McGuinness, Edward Francis, D.O., 1953 (Univ. Melbourne); Windsor, John Clement, F.R.C.S. (England), F.R.C.S. (Edinburgh), 1950; Forbes, Harold William Arthur, D.C.H., R.C.P. and S. (London), 1953.

Congresses.

SIXTH INTERNATIONAL CANCER CONGRESS.

The Sixth International Cancer Congress will be held at Sao Paulo, Brazil, from July 23 to 29, 1954. The President of the Congress is Professor Antonio Prudente, of Sao Paulo, from whom further information may be obtained.

Notice.

CRICKET.

The annual doctors *versus* dentists cricket match will be played at Sydney Cricket Ground Number 1 on Wednesday, January 20, 1954, commencing at 10.30 a.m. Any doctors wishing to be considered for selection in this team are requested to telephone either Dr. W. L. Calov (BW 7208 or FM 4237) or Dr. F. M. Farrar (BW 1291 or JJ 1818) before Wednesday, January 13, 1954.

Nominations and Elections.

The undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

Pepper, Arthur Cecil, M.B., B.S., 1952 (Univ. Sydney), 43 Hillcrest Avenue, Epping, New South Wales.

The undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

Downing, Bruce Jacob, M.B., B.S., 1953 (Univ. Adelaide) (qualified 1952), 17 Victoria Avenue, Unley Park, South Australia.

Paull, Torrance Arnold, M.B., B.S., 1953 (Univ. Adelaide), 508 Magill Road, Magill, South Australia.

The undermentioned has been elected as a member of the South Australian Branch of the British Medical Association: Lindon, Marten Edward, M.B., B.S., 1953 (Univ. Adelaide) (qualified 1952).

Medical Appointments.

Pursuant to the provisions of the *Quarantine Act*, 1908-1950, Dr. Ian Dan Carter has been appointed a Quarantine Officer, and Dr. William Herbert Benson and Dr. Bryan Ernest Cohen have been appointed Quarantine Officers at Port Victoria (South Australia) and Broome respectively.

Dr. E. S. A. Meyers has been appointed director of the School Medical Service in the Department of Public Health of New South Wales.

Dr. G. H. Jones has been appointed honorary clinical assistant in the X-Ray Department of the Royal Adelaide Hospital.

Sir Philip Messent has been appointed an honorary consulting surgeon at the Royal Adelaide Hospital.

Diary for the Month.

JAN. 5.—New South Wales Branch, B.M.A.: Council Quarterly.

JAN. 6.—Western Australian Branch, B.M.A.: Council Meeting.

JAN. 12.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federal Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178 North Terrace, Adelaide): All Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Norseman Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journals unless such notification is received within one month.

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